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the West Virginia Medical Journal

OFFICIAL ORGAN OF
E WEST VIRGINIA STATE
MEDICAL ASSOCIATION

Vol. 69 No. 1

MDS

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1973

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JANUARY 1973

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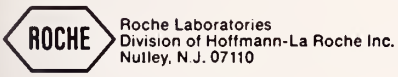
While Valium can be a most elpful adjunct to your counseling, should be prescribed only as long ; excessive psychic tension per- sts and should be discontinued hen you decide it has accom- lished its therapeutic task. In eneral, when dosage guidelines re followed, Valium is well olerated (see Dosage). For con- enience it is available in 2-mg, 5-mg nd 10-mg tablets.

Drowsiness, fatigue and ataxia ave been the most commonly re- orted side effects.

Until response is determined, atients receiving Valium should e cautioned against engaging in azardous occupations requiring omplete mental alertness, such s driving or operating machinery.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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(diazepam)

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JANUARY
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Vol. 69 No. 1

The
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Medical Journal

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lications Acute gouty arthritis, rheumatoid arthritis, ɜumatoid spondylitis

ntraindications: Children 14 years or less; senile pa- nts; history or symptoms of G I inflammation or ul- ration including severe, recurrent or persistent dys- psia; history or presence of drug allergy, blood scrasias; renal, hepatic or cardiac dysfunction; hy- rtension; thyroid disease; systemic edema, ɔmatitis and salivary gland enlargement due to the ug; polymyalgia rheumatica and temporal arteritis; tients receiving other potent chemotherapeutic ents, or long-term anticoagulant therapy

'arnings: Age, weight, dosage, duration of therapy, ex- ence of concomitant diseases, and concurrent potent ɪemotherapy affect incidence of toxic reactions. Care- lly instruct and observe the individual patient, espe- ally the aging (forty years and over) who have creased susceptibility to the toxicity of the drug Use west effective dosage Weigh initially unpredictable nefits against potential risk of severe, even fatal, re- ctions The disease condition itself is unaltered by the ug. Use with caution in first trimester of pregnancy ɪd in nursing mothers Drug may appear in cord blood ɪd breast milk Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination Swelling of ankles or face in patients under sixty may be prevented by reducing dosage If edema occurs in patients over sixty, discontinue drug.

Precautions The following should be accomplished at regular intervals Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc Cases of leukemia have been reported in patients with a history of short- and long-term therapy The majority of these patients were over forty Remember that arthritic-type pains can be the presenting symptom of leukemia

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G I bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement (B)98-146-070-G

Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.

For complete details, including dosage, please see full prescribing information.

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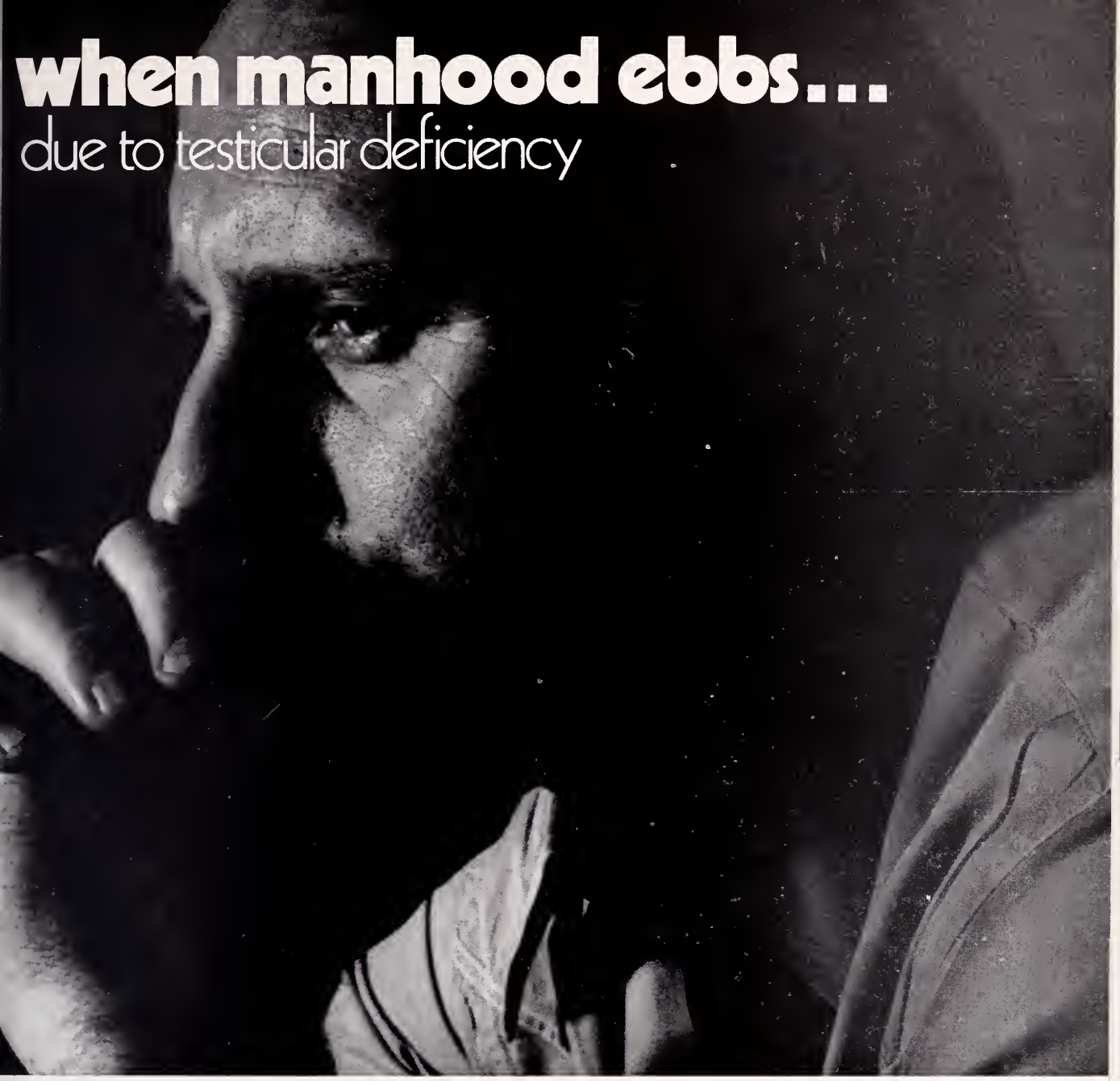
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(fluoxymesterone Tablets, U.S.P., Upjohn)

Indications in the male: Primary indication in the male is replacement therapy. Prevents the development of atrophic changes in the accessory male sex organs following castration:
1. Primary eunuchoidism and eunuchism. **2.** Male climacteric symptoms when these are secondary to androgen deficiency. **3.** Those symptoms of panhypopituitarism related to hypogonadism. **4.** Impotence due to androgen deficiency. **5.** Delayed puberty, provided it has been definitely established as such, and it is not just a familial trait.
In the female: 1. Prevention of postpartum breast manifestations of pain and engorgement. **2.** Palliation of androgen-responsive, advanced, inoperable female breast cancer in women who are more than 1, but less than 5 years post-menopausal or who have been proven to have a hormone-dependent tumor, as shown by previous beneficial response to castration.
Contraindications: Carcinoma of the male breast. Carcinoma, known or suspected, of the prostate. Cardiac, hepatic or renal decompensation. Hypercalcemia. Liver function impairment. Prepubertal males. Pregnancy.
Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.
Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.
Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.
How Supplied
2 mg—bottles of 100 scored tablets.
5 mg—bottles of 50 scored tablets.
10 mg—bottles of 50 scored tablets.
For additional product information, see your Upjohn representative or consult the package circular.
MED 8-6-S (MAH)

JA71-1008R

Upjohn

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The Upjohn Company, Kalamazoo, Michigan 49001

Gantrisin® (sulfisoxazole) Roche® provides your patients with many important advantages:

- high urinary levels
- generally good tolerance
- high solubility at average urinary pH
- rapid absorption
- rapid renal clearance
- high plasma concentrations
- economy (average cost of therapy: less than 6½¢ per tablet)

Before prescribing, please consult complete produc information, a summary of which follows:

Indications: Nonobstructed urinary tract infection (mainly cystitis, pyelitis, pyelonephritis) due to sus ceptible organisms. **Important Note:** ***In vitro* sen sitivity tests not always reliable; must be coordinate with bacteriological and clinical response. Ad aminobenzoic acid to follow-up culture media. In creasing frequency of resistant organisms limits use fulness of antibacterial agents, especially in chroni and recurrent urinary infections.** Maximum safe tot sulfonamide blood level, 20 mg/100 ml; measur levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides infants less than 2 months of age; pregnancy at ter and during the nursing period.

Warnings: Safety in pregnancy not established. D not use for group A beta-hemolytic streptococcal in fections, as sequelae (rheumatic fever, glomerulone phritis) are not prevented. Deaths reported fro hypersensitivity reactions, agranulocytosis, aplasti anemia and other blood dyscrasias. Sore throat, feve pallor, purpura or jaundice may be early indication of serious blood disorders. CBC and urinalysis wit careful microscopic examination should be performe frequently.

Precautions: Use cautiously in patients with impaire renal or hepatic function, severe allergy or bronchia asthma. Hemolysis, frequently dose-related, may oc cur in glucose-6-phosphate dehydrogenase-deficien patients. Maintain adequate fluid intake to preven crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocy tosis, aplastic anemia, thrombocytopenia, leukopenia hemolytic anemia, purpura, hypoprothrombinemia an methemoglobinemia; *Allergic reactions:* Erythem multiforme (Stevens-Johnson syndrome), generalize skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylac toid reactions, periorbital edema, conjunctival an scleral injection, photosensitization, arthralgia and al lergic myocarditis; *Gastrointestinal reactions:* Nausea emesis, abdominal pains, hepatitis, diarrhea, ano rexia, pancreatitis and stomatitis; *C.N.S. reactions* Headache, peripheral neuritis, mental depression convulsions, ataxia, hallucinations, tinnitus, vertig and insomnia; *Miscellaneous reactions:* Drug fever chills and toxic nephrosis with oliguria and anuria Periarteritis nodosa and L.E. phenomenon have oc curred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) an oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypo glycemia as well as thyroid malignancies in rats fol lowing long-term administration. Cross-sensitivity with these agents may exist.

Supplied: Tablets containing 0.5 Gm sulfisoxazole.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

cute, recurrent or chronic nonobstructed cystitis

TWO BUILT-IN BENEFITS OF GANTRISIN®

sulfisoxazole/Roche®

1.

High urinary drug levels

Gantrisin quickly reaches peak antibacterial concentrations in the urine—usually in 2 to 3 hours. With the recommended dosage regimen, Gantrisin maintains these high urinary levels throughout therapy to combat such susceptible organisms as *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

2.

Generally good tolerance

Because of Gantrisin's high solubility and rapid excretion, therapy is relatively free of adverse reactions serious enough to require discontinuance of the drug (3.1% of 1002 patients in a recent study*). Even minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. For other possible undesirable reactions, and precautions, please see summary of prescribing information on opposite page.

*Koch-Weser, J., *et al.: Arch. Intern. Med.*, *128*:399, 1971.

For nonobstructed cystitis

begin with

Gantrisin®

sulfisoxazole/Roche®

Usual adult dosage:

4 to 8 tablets *stat*

2 to 4 tablets *q.i.d.*

ROCHE

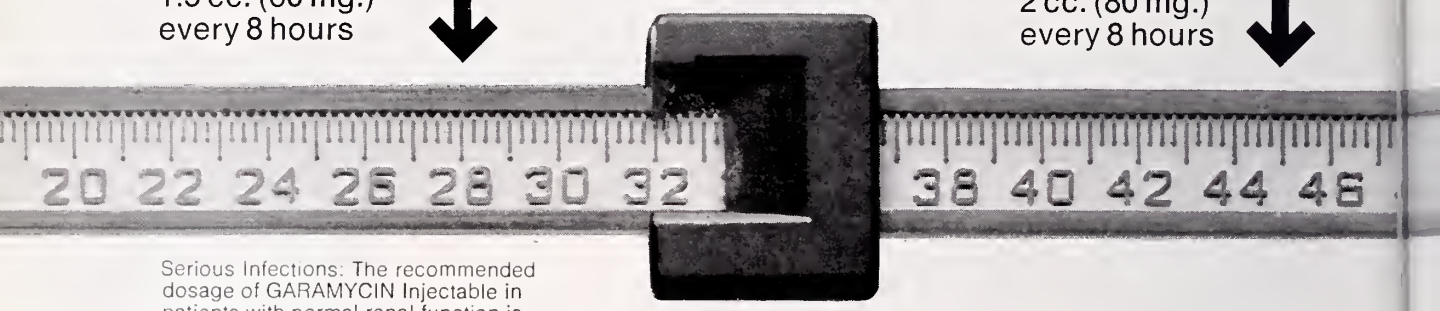
In serious gram-negative infections*

Simplified dosage guidelines

Usual adult dosage--I.M. and I.V.--in patients with normal renal function

132 lbs. or less
1.5 cc. (60 mg.)
every 8 hours

Over 132 lbs.
2 cc. (80 mg.)
every 8 hours



Serious Infections: The recommended dosage of GARAMYCIN Injectable in patients with normal renal function is 3 mg./kg./day administered in three equal doses every 8 hours.

Life-Threatening Infections: Dosages of up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

Children's Dosage—I.M. and I.V.
3 to 5 mg./kg./day in three equal doses every 8 hours.

*Due to susceptible organisms

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototo icity requires dosage adjustments or d continuance of the drug.

In event of overdose or toxic reactio peritoneal dialysis or hemodialysis will in removal of gentamicin from the blo

Serum concentrations should be monit ed when feasible and prolonged concent tions above 12 mcg./ml. should be avoid

Concurrent use of other neurotoxic an or nephrotoxic drugs, particularly strep

Schering

Garamycin®

gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Duration of therapy–I.M. and I.V.

The usual duration of treatment is 7 to 10 days. In difficult and complicated infections, a longer course of therapy may be necessary.

Instructions for I.V. use

Dilution—A single dose is diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution should not exceed 1 mg./cc. (0.1%).

Infusion time—The solution is infused over a period of 1 to 2 hours.

Premixing—GARAMYCIN Injectable should not be physically premixed with other drugs but should be administered separately in accordance with the recommended route of administration and dosage schedule.

In adults with impaired renal function

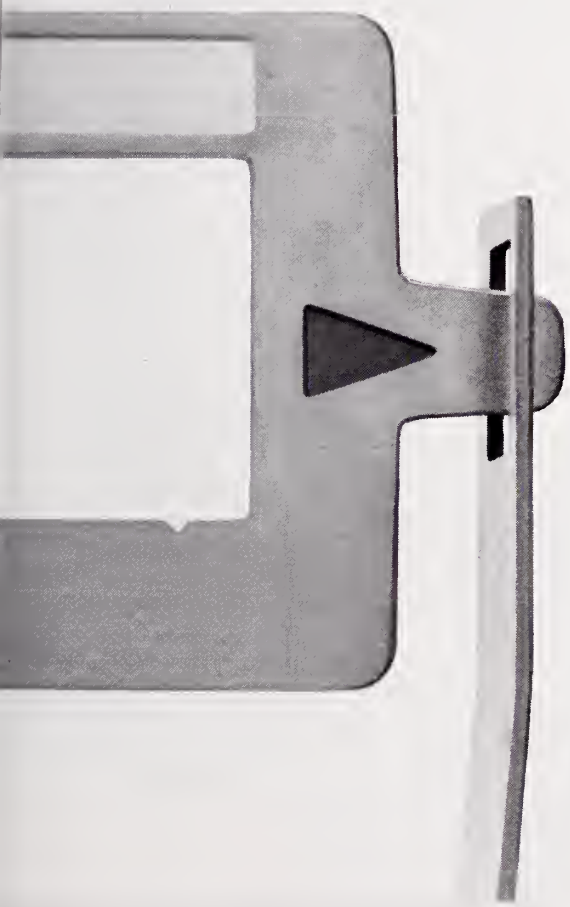
The single dose of GARAMYCIN Injectable given by patient weight remains the same; however, the interval between doses must be extended.

This interval may be approximated by multiplying the serum creatinine by eight as follows:

Serum creatinine (mg./100 ml.) $\times$ 8 = frequency of administration (in hours)

This dosage schedule is not intended as a rigid recommendation, but is provided as a guide to dosage when the measurement of gentamicin serum levels is not feasible.

See Clinical Considerations section which follows...



n, neomycin, kanamycin, cephaloridine, ycin, polymyxin B, and polymyxin E stin), should be avoided.
e concurrent use of gentamicin with po- iuretics should be avoided, since certain tics by themselves may cause ototoxic- n addition, when administered intrave- ly, diuretics may cause a rise in gentami- erum level and potentiate neurotoxicity.
GE IN PREGNANCY Safety for use egnancy has not been established.

Garamycin® Injectable
brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING: Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause toxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

SLR-192

Garamycin®

gentamicin sulfate Injectable

I.M./I.V.

40 mg. per cc.

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Advertisement

"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

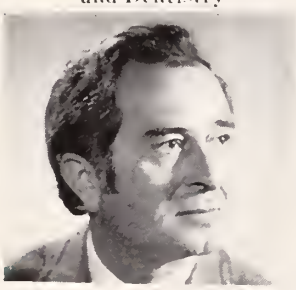
13.8%
Do not believe combination drug products are useful.

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great de of money. I wish we cou agree on a "grandfath clause" approach to prep rations that have been in u for a number of years ar that have an apparent satisfactory track record.

For example, I thi some of the antibiotic co binations that were tak off the market by the FD performed quite well. I a thinking particularly penicillin - streptomyc combinations that patien —especially surgical p tients—were given in o injection. This made f less discomfort for the p tient, less demand o nurses' time, and few opportunities for dosag errors. To take such preparation off the mark doesn't seem to be goo medicine, unless actual u age showed a great deal harm from the injectio (rather than the prop use) of the combination.

The point that should emphasized is that the are both rational and irr tional combinations. Th real question is, who shoul determine which is which Obviously, the FDA mus play a major role in mak ing this determination. I fact, I don't think it ca avoid taking the ultimat responsibility, but it shoul enlist the help of outsid physicians and experts i assessing the evidence an in making the ultimate de cision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories

If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the *usual* dose being 650 mg.

The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Not too little, not too much... but just right!

"Just right" amounts of Ilosone Liquid 250 can be dispensed easily from the pint bottle in *any* quantity you specify to meet your patients' precise needs— without regard to package size.

ready-mixed

Ilosone® Liquid 250

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

Additional information available to the profession on request.
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Indianapolis, Indiana 46206

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The West Virginia Medical Journal

Vol. 69, No. 1 January, 1973

Ankle and Knee Injuries at West Virginia University Before and After Astro Turf

K. Douglas Bowers, Jr., M. D.

The purpose of this paper is to present a comparison of the incidence of football knee and ankle injuries at West Virginia University before and after conversion to artifieial turf. The period under consideration begins with Spring football practice in 1967 and ends with the completion of Spring praetice in 1972.

The present artificial surface was installed during the summer of 1969. This study, therefore, consists of three Spring practice periods (1967, 1968, 1969) and two Fall seasons (1967, 1968) on natural turf; and three Spring practiees (1970, 1971, 1972) and three Fall seasons (1969, 1970, 1971) on artificial turf.

After conversion to artificial turf, some practices were held on natural turf. Injuries incurred during these practices, and those sustained on natural surfaces under game conditions away from home, were not included in the statistics beginning with the Fall of 1969. Injuries occurring during the extra practice sessions prior to the Peach Bowl were omitted.

There were 10 scheduled games in 1967, 1968, and 1969, and 11 in 1970 and 1971. Open dates during the 10-game seasons resulted in approximately the same number of practiec days for all seasons considered. The number of players participating each year was essentially the same. Only injuries to WVU players were included. Age, eonditioning, size, previous experience, training methods and length of practice periods all were essentially the same each year. The statistics reeorded are based on the evaluation of a single examiner, the author. The only significant variable during the entire time of the study is the shoe-playing surface interface.

The Author

- **K. Douglas Bowers, Jr., M. D., 400 Drummond Street, Morgantown, and Physician for West Virginia University Athletic Teams.**

Turf-Shoe Comparison

The natural turf was a mixture of 45 per cent Faney Kentueky Blue Grass, 40 per cent Certified Merion Strain Blue Grass and 15 per cent Recleaned Redtop Grass. Reseeding was done yearly and bare areas resodded as needed. The grass was kept at a height of 1¼ to 1½ inches. Though the field was seldom used for routine practices and saved mainly for games, it was never an ideal natural surface.

Regular low-cut football shoes with seven cleats, each with a tip diameter of ⅜ ineh and being ¾ or ½ inch long depending upon playing conditions, were worn on natural turf.

The artificial surface, Monsanto's Astro Turf, was installed during the summer of 1969. It consists of the surface, grasslike portion composed of multiple nylon filament fibers woven into a 3 mm. waterproof mat of polyester fiber and nylon tire cord. The surface fibers were originally 1 mm. wide and projected vertically upward from the mat a distance of 1 em. The mat is glued to the surface of a ⅝-inch underpad composed of a synthetic rubber and vinyl material. The underpad in turn is glued to the surface of an eight-inch layer of asphalt laid directly onto compacted soil.

On artificial turf, low-cut soccer style shoes with a molded sole varying only in cleat size and number are used. These shoes contain either

15 cleats, each ⅜ inch long with a ½-inch tip diameter, or 20 cleats ⅜ inch long and a diameter of ⅜ inch at the tip.

The present appearance of the Astro Turf little resembles the original. The grasslike layer is compacted so that the nylon fibers no longer project vertically upward 1 cm. but rather lie over in such a way that the surface thickness is now only ½ cm. Individual fibers have split and frayed. In a number of areas, the surface mat has separated from the underpad, producing a sliding surface.

Injuries Considered

This paper concentrates mainly on the incidence of knee and ankle injuries. They are the most common of the significant injuries and result in more player time lost than any other group. They are definitely directly related to the turf-shoe interface.

Knee trauma is divided into those injuries requiring surgery (both ligament and meniscus) and sprains resulting in at least three missed practices or one missed game. All recorded surgical injuries were initial episodes; that is, none was superimposed on a previously injured joint. Ankle injuries recorded include both initial and recurrent sprains resulting in three or more missed practices or at least one missed game (Chart No. 1).

Knee and ankle injuries, recorded in the same manner, occurring during two successive Spring and Fall seasons on natural turf are compared with those occurring during two successive Spring and Fall seasons on artificial turf (Chart No. 2).

Chart No. 3 is a breakdown of the severity of the knee injuries recorded in Chart No. 2. Of the five surgical knees seen in 1967 and 1968, two were isolated meniscus lesions, one was a combined meniscus, single ligament tear and two were single ligament tears. All five players returned to active competition, completing their college eligibility without reinjury. All four surgical knees in 1970 and 1971 involved ligament ruptures, and in this group is found the most extensive football knee injury I have seen and reported in the *West Virginia Medical Journal* in September of 1972. Three of these players returned to competition, and are playing now. The player sustaining the extensive injury is recovering satisfactorily, but will probably never be able to play again.

Discussion

In April of 1968, Monsanto Company, makers of Astro Turf, published a report claiming up to an 80 per cent reduction in football knee and ankle injuries when using Astro Turf as compared to grass. Their explanation for the claimed reduction was that on Astro Turf, cleats do not penetrate the surface, thus eliminating foot lock and thereby preventing transmission of stress to the ankle and knee. The fact that cleat penetration doesn't occur may well be true (especially on the well compressed surface of Mountaineer Field). It is, however, obvious that at WVU, injury reduction has not resulted from conversion to Astro Turf.

Other factors must therefore be instrumental in the injuries occurring on Astro Turf. Two such factors which I feel are of importance in this regard are friction and impact absorption. We are currently investigating these and other characteristics of Astro Turf.

Statistics on contusions, lacerations, concussions and other injuries probably not turf-related have not been accurately compiled. They were briefly reviewed and, in general, were much the same, both in number and severity, during the years before and after artificial turf. Also, since 1967, there have been two major fractures on

Chart No. 1

Significant knee and ankle injuries from Spring of 1967 through the Spring practice of 1972

	Natural Turf					Artificial Turf					
	1967		1968		19	69	1970		1971		1972
	Spring	*Season*	*Spring*	*Season*	*Spring*	*Season*	*Spring*	*Season*	*Spring*	*Season*	*Spring*
KNEE											
Surgical (meniscus and ligament)	2	2	0	1	1	2	0	1	1	2	1
Nonsurgical (missed at least 3 practices or 1 game)	4	5	1	3	2	6	3	3	5	8	4
ANKLE (missed at least 3 practices or 1 game)	6	10	7	11	5	12	5	12	7	11	4

Chart No. 2

Significant knee and ankle injuries, two complete years on natural turf compared to two complete years on artificial turf.

		Natural Turf '67-'68	Artificial Turf '70-'71
KNEE	Surgical	5	4
	Nonsurgical	13	19
ANKLE		34	35

Mountaineer Field. Both were midshaft fractures of the tibia and fibula requiring closed reduction and cast immobilization. One occurred in 1967 on natural turf, the other in 1972 on Astro Turf. Neither involved a WVU player. The fact that the most severe football knee injury I have ever encountered occurred on Astro Turf may be coincidental, and, as reported, this specific injury would probably have occurred on any surface, but it did occur on Astro Turf.

Astro Turf has apparently produced new problems. Skin abrasions are much more common, especially on the extremities. Although some have been rather extensive, none has resulted in player time lost, and there have been no secondary infections. Chronic strain of the plantar capsule and ligaments of the great toe metatarsal phalangeal joint seems to be directly related to artificial turf. It has been a significantly disabling factor in at least six players over the past two years, and was not seen as such prior to the fall of 1969.

It must be kept in mind that the injuries here recorded as occurring on natural turf did not occur on an ideal natural turf. It would be most interesting to see what effect conversion to such a surface would have. It must also be considered that our present artificial surface is inferior, although felt to be the best available by those who made the decision to convert when installed in 1969.

Conclusion

The conversion to artificial turf on Mountaineer Field has not resulted in a significant decrease in the number of knee and ankle injuries at WVU.

Knee injuries occurring on artificial turf at Mountaineer Field have been as severe, if not more so, than those which occurred on the old natural surface.

Factors such as friction and impact absorption may play an important role in the production of injuries on Astro Turf.

New problems have been created with the use of Astro Turf.

The question created by the development of artificial surfaces as to their superiority over natural turf regarding injury reduction must be much more thoroughly researched before further claims are made.

A list of references may be obtained by writing The Journal.

Chart No. 3

Severity of knee injuries, full year, 1967-1968 vs. 1970-1971

	Natural Turf '67-'68	Artificial Turf '70-'71
SURGICAL	(5) 1. medial meniscus medial collateral ligament 2. lateral meniscus 3. medial collateral ligament 4. medial meniscus 5. medial collateral ligament	(4) 1. medial meniscus medial collateral ligament 2. medial collateral ligament 3. medial collateral ligament 4. anterior cruciate ligament posterior cruciate ligament posterior and lateral capsule biceps femoris tendon ilio-tibial tract popliteus tendon lateral head of gastrocnemius lateral collateral ligament peroneal nerve palsy
NONSURGICAL	(13) 2 requiring cast immobilization	(19) 4 requiring cast immobilization

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Clinical Applications of the Carotid Sinus Reflex*

Stephen F. Vatner, M. D.

For the past half century, the carotid sinus reflex has been in focus of intense physiological interest and investigation. This fundamental cardiovascular reflex influences and regulates arterial pressure, heart rate, myocardial contractility and peripheral vascular resistance. Recently, exogenous stimulation of this reflex has been employed as a diagnostic and therapeutic tool.

The carotid sinus is a dilatation of the internal carotid artery near its origin at the bifurcation of the common carotid artery. Afferent information from the carotid sinus is relayed to the cardiovascular centers in the brainstem via the carotid sinus nerve, a branch of the glossopharyngeal. The efferent loop of the carotid sinus reflex comprises both sympathetic and parasympathetic pathways to the heart which influence heart rate and myocardial contractility and sympathetic pathways to the adrenal medulla and the peripheral arterial and venous vasculature. The reflex functions as a negative feedback system, i.e., an increase in arterial pressure increases afferent nerve traffic to the cardiovascular center, which in turn reflexly reduces peripheral vascular resistance, heart rate, myocardial contractility, and circulating catecholamines; all of which tend to return arterial pressure to control. Carotid sinus hypotension produces opposite results. A similar reflex arises from a pressure sensing mechanism located in the aortic arch. These reflexes comprise the major baroreceptor systems. The baroreceptors serve to maintain arterial pressure and cardiovascular dynamics relatively constant.

Excessive activation of the carotid sinus reflex may produce carotid sinus syncope. Susceptible patients with a hyperactive carotid sinus reflex are therefore prone to episodic hypotension and syncope; characteristically in elderly men especially, those who wear high, tight collars, and young women just prior to menstruation. Patients afflicted with Takayasu's syndrome, a nonspecific arteritis affecting the subclavian and carotid arteries of young women, are susceptible to carotid sinus syncope.

*Provided by the West Virginia Heart Association.

The Author

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One Maneuver

One established therapeutic and diagnostic maneuver involving the carotid sinus is differentiation of supraventricular from ventricular arrhythmias and the interruption of paroxysmal atrial tachycardia by manual carotid sinus massage. Massage simulates arterial hypertension and results in a reduction of sympathetic tone and a simultaneous increase in vagal tone to the heart. Thus, automaticity decreases, conduction slows and the tachycardia is frequently abruptly terminated.

Carotid sinus massage has several potential pitfalls. The technique cannot be applied to all patients since carotid blood flow may be compromised in the presence of coexisting cerebral vascular disease. Syncope, cardiac standstill due to excessive vagal inhibition of the sino-atrial or AV nodes; dislocation of an arterial thrombus or plaque with consequent cerebral embolism are potential risks that can be minimized by careful monitoring of heart rate and limitation of duration of compression.

The carotid sinus nerves can be activated by a new technique now utilized for interrupting disabling, recurrent attacks of paroxysmal atrial tachycardia. The baroreflex is activated by electrical stimulation of the carotid sinus nerves, again, like manual stimulation, stimulating the afferent limb of the reflex arc and tending to slow the heart rate and interrupt the attack by decreasing sympathetic tone and increasing vagal restraint. At operation electrodes are implanted bilaterally on the carotid sinus nerves and a radiofrequency receiver attached to the electrodes is placed in a subcutaneous pocket. After recovery from operation the patient activates a radiofrequency pacemaker* to stimulate the carotid sinus nerves electrically via the receiver-electrode circuit. Thus, the reflex

*Medtronic, Inc., Minneapolis, Minnesota.

can be activated immediately by the patient as needed, stimulation can be discontinued abruptly, and stimulation may be initiated safely and repeatedly.

Diagnosis Tool

Carotid sinus massage has been used as a tool in the diagnosis of angina pectoris for many years. Recently carotid sinus nerve stimulation has been employed also in the therapy of angina pectoris by Braunwald and co-workers. Angina pectoris results from a disparity between the oxygen requirements of the myocardius and oxygen availability via myocardial blood supply. Electrical stimulation of the carotid sinus nerves tends to diminish the myocardial oxygen requirements primarily by reducing arterial pressure, left ventricular afterload and myocardial wall tension, while it reduces heart rate and myocardial contractility to a lesser extent. In addition, carotid sinus nerve stimulation produces reflex coronary vasodilatation through a reduction in resting sympathetic coronary constrictor tone. The reduction in myocardial oxygen requirements and possibly increased supply has proven to be beneficial to patients utilizing electrical carotid stimulation to terminate attacks of angina pectoris.

Since the main function of the carotid sinus reflex is to regulate arterial pressure, carotid sinus nerve stimulation has been utilized in the therapy of the most common disorder of blood pressure, essential hypertension. Altered function of this reflex may contribute to sustained hypertension in this disorder. Persistent electrical carotid sinus stimulation has lowered blood pressure substantially for as long as five years. In some cases actual regression of eyeground changes have occurred. This technique, in association with antihypertensive drug therapy, is being used successfully for the treatment of moderate and severe hypertension.

Experiments In Animals

Activation of the carotid sinus reflex is a useful diagnostic tool. Experiments in animals by Vatner and associates have demonstrated that the characteristics of the reflex change with altered states of consciousness, i.e., a differential pattern of autonomic outflow occurs in the conscious organism as opposed to during sleep or after general anesthesia. Baroreceptor function can be assessed in man by measurement of heart rate after administration of angiotensin intravenously. This drug raises arterial pressure by increasing peripheral resistance. The elevated arterial pressure then causes reflex slowing of heart rate. The relationship between the rise in arterial pressure and reflex slowing has been characterized in normal individuals and has been found to be altered in patients with hypertension and those with congestive heart failure. Diminished baroreceptor sensitivity has been demonstrated in both these disease states and may contribute to maintenance of essential hypertension.

Thus, the carotid sinus reflex, a cornerstone of cardiovascular physiology for half a century, is now being utilized in cardiovascular diagnosis and therapy. Electrical stimulation of the carotid sinus nerves is being employed to treat angina pectoris, recurrent supraventricular tachycardia, and essential hypertension. In addition, altered responsiveness of the baroreceptors in disease states may be valuable diagnostically and may provide further understanding of the pathophysiology of several circulatory disturbances.

Everything has been thought of before, but the difficulty is to think of it again.

GOETHE

Current Aspects of Digitalis Therapy*

Joel S. Karliner, M. D.

In recent years, substantial information regarding the mechanisms of action of the digitalis glycosides has accumulated. It is now generally accepted that the beneficial effects of digitalis in patients with congestive cardiac failure result from direct stimulation of the contractile state of the myocardium. Thus, in hemodynamic studies on patients exhibiting chronic heart failure of the low output type, it has been shown that digitalis augments the cardiac output and lowers the abnormally elevated left ventricular end-diastolic pressure. It has also been demonstrated that even though cardiac glycosides exert little effect on the pumping action of the normal ventricle as expressed in the cardiac output, they do exert a stimulating influence on normal cardiac muscle.

Myocardial Oxygen Balance

Among the major determinants of cardiac performance is the balance between oxygen supply and demand. Myocardial oxygen consumption (MVO_2) depends upon a number of factors, the most important of which are heart rate, wall tension (which is directly related to intraventricular pressure and heart size) and the contractile state of the myocardium. It appears that the increase in contractility produced by digitalis augments MVO_2. However, reduction in heart rate caused by digitalis tends to have the opposite effect. In the dilated, failing heart, which becomes smaller after glycoside administration, the concurrent reduction in wall tension counteracts the oxygen cost of augmented contractility. Thus the effects of digitalis on MVO_2 depend on the state of compensation existing at the time the drug is administered.

Vascular Effects

The effects of digitalis on flow and resistance in various vascular beds have only recently been determined in the conscious dog. After the animal's full recovery from the implantation of Doppler flow probes on the aorta and left circumflex coronary, it was found that ouabain caused coronary vasoconstriction despite the increase in MVO_2 which would have been expected to produce dilatation in the coronary vascular bed. Whether the results in a normal dog are applicable to patients with coronary vascular disease remains to be demonstrated. In normal conscious dogs with chronically implanted flowmeters, digitalis causes constriction in the renal and iliac beds, but dilatation in the mesenteric bed. In contrast, in dogs with heart failure, flow increased in all beds studied and vasodilatation occurred in response to ouabain, presumably as a consequence of increasing cardiac output, thereby reducing the reflex vasoconstriction which characterizes the low output state.

Myocardial Infarction

Although digitalis is unequivocally indicated for left ventricular failure complicating chronic valvular and coronary artery disease, the available experimental and clinical data still leave many unanswered questions concerning the role of digitalis therapy after acute myocardial infarction. It is postulated that the fate of the peri-infarction zone, with the limited oxygen available to it, is influenced profoundly by the oxygen requirements of the tissue. Increasing the latter in the nonfailing heart of dogs with experimental myocardial infarction by means of ouabain and other positive inotropic stimuli intensifies ischemia, and ultimately results in more extensive infarction. In contrast, reducing myocardial oxygen demands by administering digitalis to the infarcted heart which is failing, may permit survival of the underperfused zone bordering the infarct.

Thus it seems clear that little is to be gained by glycoside administration to patients with uncomplicated infarction who do not have cardiomegaly. The role of digitalis therapy in the treatment of cardiogenic shock remains undefined, but based on the data available, its efficacy in this syndrome must be questioned. Digitalis appears to be indicated for the treatment of rapid atrial fibrillation complicating acute myocardial infarction. Other supraventricular

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*Provided by the West Virginia Heart Association.

arrhythmias, such as atrial flutter and ectopic atrial tachycardia, frequently require larger doses of the glycoside and other means of therapy, such as antiarrhythmic agents or electrical conversion, may be preferable in such instances. Digitalis is commonly utilized early in the treatment of congestive heart failure and cardiomegaly complicating acute myocardial infarction, despite the paucity of experimental and clinical evidence in support of such therapy. Whether the digitalis glycosides should continue to be used routinely in such patients remains a subject for continuing clinical investigation.

Pharmacology and Assay

The metabolic half-times and excretion rates of short, intermediate, and long acting glycosides have been well characterized. Renal insufficiency as well as old age are associated with impaired renal excretion of digitalis glycosides, suggesting that digitalis dosage should be modified in such patients.

More recently, radioimmunoassay for serum digoxin concentration has come into routine clinical use in a number of centers. Serum digoxin concentrations exceeding 2 nanograms (ng)/ml appear to be associated with an increased frequency of toxic manifestations. Smith and Haber reported that patients with supraventricular tachycardia and block apparently induced by digitalis, and those with ventricular dysrhythmias had mean serum digoxin concentrations of 4.1 and 3.7 ng/ml, respectively. In contrast, patients with atrial fibrillation who had a reduced ventricular response and ventricular premature beats, and patients with sinus rhythm and second or third degree atrioventricular block, had levels of 2.2 and 3.2 ng/ml, respectively. Overlap may occur and patients with levels considerably greater than 2.0 ng/ml may have no symptoms, while those with lower levels (but usually not less than 1.6 ng/ml) may demonstrate electrocardiographic abnormalities, especially ventricular premature beats. Nevertheless, in patients whose serum digoxin levels exceed 2 ng/ml, it is prudent to discontinue the glycoside until the serum level falls below this concentration. With the availability of this radioimmunoassay technique, it should be possible to analyze critically digitalis dosage schedules in relation to evidence of both beneficial effects as well as toxicity in patients with acute myocardial infarction and to determine definitively whether acute myocardial infarction sensitizes patients to digitalis-induced arrhythmias.

Much Work Remains

Although our knowledge of the mechanisms of action and clinical utilization of this most useful of cardiac drugs has advanced considerably in the past decade, much work remains. Directions for future basic research include clarification of the digitalis receptor and definition of the subcellular mechanism of glycoside action. On a clinical level, digitalis use in acute myocardial infarction in man remains an important topic for future investigation.

What Shall We Tell The Patient?

It's easy to tell someone his stock has gone up, or he's going to live, and it is traditional to reward the bearer of good tidings. But the bringer of unpleasant information is disliked and is somehow associated with the disaster he tells of. The doctor who says the patient is well is credited with the recovery. But while it is no easy thing to tell someone he must die, it is the physician's burden that he must be the first to know when the last of the fates stands ready to cut the thread of life.

Some tell the patient right away when the news is bad, some answer the questions honestly, some tell the wife or husband, and some offer hope until the end. But the fates are outnumbered by the panelists, who rarely agree but nonetheless advise. One expert tells, one gives hope, one preaches honesty; they do what we do, and there's an end on't.

If there's a best way, the panelists have not said so; if it depends on the patient, we knew that. If the experts are going to say "What do you think?" to each other, we can do as well.

What do I want to be told when it's time? Who knows? I don't, not yet. I don't think you do. And I don't think all those panels do, either.—*F. C., in Nebraska Medical Journal.*

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Special Article

The Free Clinic Movement Enters West Virginia

Walter A. Morgan, M. D.

Over the past 10 years, a new form of medical care delivery has appeared in various places in the country based on voluntarism and geared to meet the needs of specific groups of people. These efforts are referred to as "free clinics." They have characteristics which distinguish them from their predecessors in the altruistic medical care area.[7] One of these free clinics recently has been established in West Virginia. The purpose of this paper is to discuss the national movement, and to describe the West Virginia clinic as both a part of and a contrast to that national movement.

With the explosion of the unique youth subculture during the 1960s, with the "hippie" movement, drug abuse, increased sexual freedom, and student activism, large communities of youth in the country became an alienated group detached from or unable to accept the established methods of health care delivery. Clinics appeared which responded specifically to meet the needs of these groups.[2] At the same time, new volunteer efforts to provide health care to ghettos and other poverty areas developed across the country, spurred on by the civil rights movement, black nationalism and ethnic self-identity trends.[6]

Please see editorial on this subject on page 17

These efforts followed the historical tradition of altruistic service to the needy long provided by churches, voluntary institutions and individual providers. These traditional services, however, have proven quantitatively inadequate and often not able to cope with the particular cultural or even medical needs of specific groups. The new free clinics more often took the nature of self-help efforts, with strong leadership from the target group itself, and developed services and attitudes specifically tailored to the needs of the group.

Nationwide Common Ground

Beyond the local response to local need, there became a nationwide common ground among these clinics which, in essence, states that the health care delivery system (or non-system) in this country has failed to meet the needs of many groups of people, and that better ways must be found to deliver needed care.[5]

The Author

- **Walter A. Morgan, M. D., Associate Professor of Public Health, West Virginia University Medical Center, Morgantown.**

Thus it was that two types of individuals might be associated with the free clinic movement. One set would be individuals primarily interested in personally working with people on a one-to-one basis, to learn more about others' needs, and to help others in whatever capacity possible. Another group, made up of political activists, utilized the free clinic as a means to probe, challenge and possibly reform the whole health care delivery system on a local or even national scale.

By 1970, hundreds of free clinics had appeared across the country. These ranged from centers for health education and referral staffed by nonmedical personnel, through special clinics for special purposes such as birth control, drug abuse, venereal disease, to complete medical facilities staffed with a full array of medical and dental personnel offering a complete battery of services.

Free Clinics Inventory

The first inventory of free clinics in America was done by Jerome Schwartz, Ph. D.[3, 4] when he was a visiting professor to the West Virginia University School of Medicine, Division of Preventive Medicine, 1970-71. He developed a working definition of a free clinic based on seven criteria:

1. Direct delivery of medical care, dental care, or psychological and drug abuse care.
2. Presence of a professional relevant to the service provided.
3. Services available to everyone without red tape or eligibility tests.

4. In general, no direct charges, although small charges for specific services or donations may be requested.
5. At least some volunteer professionals on the staff.
6. Specified hours of service.
7. Care provided from a facility.

In 1970, over 200 clinics met these criteria.

In 1971, a meeting of some of the people who were aware of the movement was held, and a "National Free Clinic Council" was established.[5] The initial president was David E. Smith, M. D. and a pharmacologist, who began the renowned Haight-Ashbury Clinic for drug abuse in San Francisco. The second meeting was planned for early 1972, and the meeting was promoted by the Medical Committee on Human Rights and other publications. In January, 1972, over 180 of the clinics were represented in the second annual symposium of the National Free Clinic Council held in Washington, D. C. This meeting was financially supported by the Department of Health, Education and Welfare and by the Pfizer Pharmaceutical Corporation.

Unstructured Program

The program was quite unstructured as would be appropriate to independent youth activists, and ad hoc sessions and caucuses developed almost every hour. There was remarkably good exchange among the clinic representatives concerning experiences and ideas on outreach, resources, and getting more out of the establishment. The open sessions, however, attended by several hundred people, were often tumultous and on occasion collapsed in chaos.

The one basic issue was, "What is the purpose of a free clinic?" A majority felt the clinics were doing a job providing services to needy groups, and these groups wished to retain the clinic's independence and to continue their work, although recognizing that the quality of care provided was not excellent. Another group felt that the free clinics were primarily an "ego trip" on the part of the volunteers, providing at best "band-aid medicine," and that their only purpose should be as a focal point for national action to reform the entire health care system. The second related question was whether a National Free Clinic Council should be established, and whether clinics should join it to have national voice. During the closing hours of the weekend, the remnants determined that a national council would be established with which clinics could be associated if they so desired.

A few months thereafter, it was indeed announced that the Federal Government was willing to grant up to $1 million to the National Council for distribution to individual free clinics who could run meaningful drug abuse programs. The President's Special Action Office on Drug Abuse Prevention was earnestly seeking groups who had proved that they could reach drug users and win their confidence, and was eager to enable these groups to do more effective work through whatever grant support the clinics found necessary. The political activists, however, regarded this as selling out the free clinics to the government, thereby ending any meaningful opportunity to effectively challenge the health care system in this country.[1] In addition, they charged that the entire symposium was rigged by Doctor Smith to win that grant.

Meanwhile, most free clinics continue to work as they had in the past, staffed primarily by young people interested in helping their fellow man; scratching to gather adequate equipment, supplies, space and operating expenses, and quite willing to accept whatever support the drug companies or other elements of the establishment are willing to give in order to provide better service. The national political issue apparently affects only a few.

The West Virginia Clinic

Around Morgantown, West Virginia, several forces were ultimately to join in the formation of a free clinic in Osage, Monongalia County. One force was the Scott's Run Settlement House, established by the Methodist Board of Missions in 1924 and still operating as a church and community service agency with many activities serving the generally impoverished area of Scott's Run. Its director long has sought improved health care resources for the community. Although directly across the river from Morgantown, it has no local medical care and much of the population is too poor to have access to private care or is unable to reach medical care because of poor transportation or infirmity. The Monongalia County Health Department provides a well-baby clinic at the Settlement House, and the area is also served by the Maternal and Infant Care Project, but other primary care is not available. The Settlement House Director had approached the West Virginia University Medical Center on several occasions for direct clinical care and a proposal for a clinic to be financed by the Office of Economic Opportunity was submitted three years ago and was approved in principle—but not funded.

A second force developed in 1971 among second-year medical students who were interested in establishing a meaningful service program in the area. Concommitantly, students of other schools in the University were involved in outreach and service programs in the local area such as social work and school tutoring. Health science students had been involved in health education and an intestinal parasite screening program with treatment and follow-up, utilizing medical, medical technology, nursing and pharmacy students. All of these students were seeking a more permanent project which would have a greater meaning, especially if the team approach could be utilized. Two medical students began actively to explore the possibilities of a free clinic.

A third factor at work was the Division of Preventive Medicine of the Medical School which sought to develop a community based project which could better acquaint medical students with the environmental, socioeconomic, and family context of health and illness; and which could serve at least a small group of people in an effective way, utilizing various innovative approaches. A fourth force arose in the person of one young undergraduate formerly associated with a free clinic in Illinois, who independently discovered the need for a free clinic in Osage and simply began, in early 1972, to gather the necessary community support for such a project.

Students and faculty of all health science disciplines met regularly through the winter of 1971-72 in an attempt to develop a program which would be acceptable to the University administration as an official educational program. Official sanction was not obtained. The project was not of sufficient interest to clinical departments (Medicine and Pediatrics), and they did not wish to assume responsibility or provide assurance of a continuing high-caliber operation. Although University sponsorship would have meant recognition of the teaching value of a community clinic, as well as more support services to the patients, and extension of malpractice insurance coverage to most professional volunteers, the clinic's independence from the University allowed possibly more freedom for innovation, informality, and emphasis on the volunteer attitude.

These forces finally joined in the spring of 1972. Operating procedures and schedules were established and equipment was gathered from a variety of donors, including the University. The community itself raised money to buy some equipment and purchase a malpractice insurance policy written especially for free clinics. Community members subsequently founded a non-profit corporation with the help of the Legal Aid Society and has since written by-laws and elected officers. On May 1, 1972, the first clinic was held.

The Scott's Run Medical Clinic

For the students, the Scott's Run Medical Clinic is an opportunity to take responsibility in the area of primary care in an informal setting and to explore a different means of health care organization. For many, it is the opportunity to become personally involved in the administration of such an operation. For both pharmacy and nursing, it has been an opportunity to explore new roles as both are taking partial clinical histories and pursuing follow-ups in their respective areas of concern. For all health professionals, it is an opportunity to experience the team concept of health care on a small scale. For the individual patients, the clinic represents the first resource of primary care in their community. For the populace at large, it is an appreciated expression of concern by health professionals in response to the community's lack of health care.

Operations of The Clinic

The clinic meets Monday and Thursday evenings from 7:00 until 10:00 or 11:00 o'clock. Members of the community have attempted to identify shut-ins and previously alienated individuals who particularly need medical care, and, in addition, provide transportation and encouragement to bring these patients to the clinic. It is usually staffed by community volunteers (who act as receptionists and transportation resources for patients), by one or two licensed physicians, two medical students (third or fourth year), one registered pharmacist and a pharmacy student, one or two registered nurses and nursing students, and two licensed medical technologists.

Services performed are comparable to those in a general practitioner's office with diagnostic evaluation, treatment, and follow-up. The record system is evolving into a problem-oriented system on which several disciplines will write continuously rather than in segregated parts of the record. The laboratory provides blood counts, urinalysis, blood glucose, pregnancy tests and is able to take cultures and draw bloods for sending to commercial laboratories for other chemistries. Electrocardiograms can be performed. The nursing staff thoroughly interviews all patients and takes the initiative to follow those who in their judgment would benefit from continuous nursing care. Pharmacy usually sees patients before the physician to take careful drug histories. After the patient sees the physician, the pharmacist makes a greater than usual effort to explain the

proper self-administration of prescribed medication. Health conditions which cannot be handled at the clinic are referred either to private resources in Morgantown or the University Hospital. The clinic fund, itself, has no resources to pay the cost of those referrals, however, and for many patients this remains a hardship. For diagnostic aids done outside the clinic, such as x-ray and blood chemistries, the patient is encouraged to pay for these when he can, but the clinic funds will cover these when the patient is unable to do so.

Patients who are found to have a regular physician are encouraged to return to that physician whenever possible. However, when the patient has logistic or financial problems, the clinic will assist in the patient's care with additional visits to assess the patient's condition and forward this assessment to the private physician.

Dental activity has begun, but because of the expense of equipping such a facility, it is limited primarily to dental hygiene, instruction and screening.

Progress of First Few Months

Review of the charts of the first three months of operation, May 1 through July 31, 1972, reveals that 152 patients have been seen for 246 visits, giving an average of 9.5 visits per night. The trend has been steadily on the increase and has been running 12-16 patients per night over more recent weeks, with peaks of 25. Thirty-four per cent of the patients were seen for one or more return visits. About one and a half more females than males have been seen. Age distribution has been from three months to 91 years, with an even age distribution. The area served has been predominantly the small townships in the Cass district of Monongalia County, locally referred to as the Scott's Run Area.

Continued professional interest is demonstrated by the fact that the clinic did not miss a session throughout the summer, despite the problems of vacation relief scheduling. The first three months were a "shake-down" period with the development of medical records systems, accumulation of necessary equipment, trials at various methods of patient flow, determining levels of interest and commitment of various individuals, determining community interest and need, and developing patterns of responsibility and roles which could lead to better service and better teaching opportunities for students of nursing and pharmacy.

It has been most successful to schedule volunteers no more than once a month. This has proved feasible in some disciplines, such as Medicine and Medical Technology but, because of fewer volunteers available, may be less likely for the Nursing and Pharmacy faculty.

During the first four months, 141 volunteers have served at the clinic, including 19 community laymen, 14 physicians, 25 medical students, 17 nurses and nursing students, 32 pharmacists and pharmacy students, and 36 medical technologists.

Problems, Present and Future

1. *Space.* The clinic borrows space from the Settlement House, using four rooms of the second floor with waiting and initial interviewing on the first floor. The operation frequently disrupts the other activities of the Settlement House, and there is no room for expansion of services. Financing may be found to rent larger space, if available, if need grows and the clinic persists. The Settlement House has provided excellent support and an introduction to the community.

2. *Money.* There is no regular income. Some billing may be possible to Medicare and the Department of Welfare, but patients with this resource are not top priority.

3. *Volunteer disenchantment.* This is not yet apparent, but once the novelty and the challenge of establishing such a service is over, it may become harder to retain the interest of initial volunteers or to attract new ones.

4. *Quality.* This clinic, like most free clinics, excels in the good care criteria of accessibility, compassion and competence, but lacks comprehensive care elements and has troubles in continuity of care. In comprehensiveness, diagnostic and treatment skills are limited by the skills of the physician serving that evening (usually a faculty "internist" or resident of pediatrics or internal medicine) and x-ray facilities and procedural equipment are lacking. All of this can be arranged for by referral, but usually with difficulty. We have better use of nursing and pharmacy skills than most primary care centers. In continuity, we have the problem of a different group of people each night, with reliance on medical records for planning care. Volunteers know when they are to work again and often request patients to return at that time, but this only partly relieves the problem.

Discussion

The Scott's Run Medical Clinic represents a cooperative effort of the community, health science professionals, and students of the University. Its primary purpose is to provide a source of care for the medically indigent, and secondarily to provide a unique learning opportunity

for all of the volunteers in a community setting. While recognizing more poignantly than ever the serious deficits in health care resources in this area, the volunteers proclaim no dramatic answers to the problems revealed. Clearly, the free clinic model itself is no ultimate answer. It is not able to give ideal care under its present organization. It does not run "efficiently" given its large professional staffing pattern. Furthermore, it is not transferrable to other locations in this state or, at least, not to areas of general health manpower shortage.

What the existence of the clinic may be saying is that a community oriented, team-delivered, primary care is an important part of medical education. More explicitly, this clinic represents simply an attempt on the part of health professionals and students to be of service to one small community and to help the individuals overcome some of the barriers to good health care which so obviously exist.

Acknowledgments

The prime mover was medical student Patrick Joseph, who did most of the organizing, supply marshalling and coordination—an almost full-time job, assisted by classmate Lewis Cook. Violet Petso is the tireless director of the Scott's Run Settlement House. Frank Haymond, Social Work student, brought the idea from Illinois, renovated the space and acts as Administrator along with Dan Kuruna, also of the School of Social Work. Betty Veach, trained both in Social Work and Nursing, employed by the UMWA Welfare Office and familiar with Scott's Run needs, started us off on realistic footing. Ann Gagnon has done much of the nursing service development, including primary nurse evaluation of the patients, assisted by Clara Long. They are School of Nursing faculty. Robert Church of the Pharmacy faculty established the medicine supplies with a major assist from drug companies, and developed the drug history interview. Dan Southern, graduate Medical Technology student, established the laboratory with Pat Lamb. The author helps schedule physicians and is Associate Professor and Acting Chairman, Division of Public Health and Preventive Medicine, West Virginia University School of Medicine.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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Clinical Data:
Patient: 47-year-old male.
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Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.
Adverse Reactions: (Common to all tetracyclines, including MINOCIN) GI: (with both oral and parenteral use): anorexia, nausea, light-headedness, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
NOTE: *Concomitant therapy:* Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

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THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., Charleston.

THE REGISTRATION FEE of $15 for the two days will be charged all registrants except nurses, medical students, interns and residents; and will include admission to a group buffet luncheon on Sunday, January 21. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for credit toward the Physician's Recognition Award of the American Medical Association; and the program also has been approved for 11 hours of prescribed credit by the American Academy of Family Practice.

OVERNIGHT ACCOMMODATIONS: Physicians planning to spend one or more nights in Charleston should communicate directly with the reservation manager of the hotel or motor inn where they wish to stay.

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Please register me for the Sixth Mid-Winter Clinical Conference in Charleston, January 20-21, 1973. My $15 registration fee is (is not) enclosed.

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ECONOMICS: WHERE—WHO—HOW?

THE economics of medicine is not an exciting study for most physicians. Little, if any, emphasis is placed on economics in medical training programs, but the young physician soon becomes aware that some knowledge of the subject is desperately needed in today's jungle of government and third party involvement and control. The aware and concerned physician knows the importance of medical economic factors.

The criticism of our health care systems today is based on economic factors. The economic experts feel free to criticize our health care system and medical care because of rising medical costs. They frequently choose to ignore that most of the increase reflects our rising labor costs, cost of supplies and the decreased purchasing power of our dollars. They can only note that medical costs are higher.

Since these same medical experts cannot measure or define quality medical care, they criticize the quantity in relation to cost, things they think they can measure and define. High medical costs do not assure high quality medical care. The attempts of government agencies in health care delivery have resulted in almost unbelievable costs, and the quality of care is frequently poor.

Health care delivery will and should continue to change. Congress will continue to pass health care legislation—some of it needed. Regardless of legislation, quality medical care will never be available at all hours in every hamlet in America. But our present system has many principles—such as choice of physician and health care facility, and fee for service—which should be preserved.

There may come a time when some government unit may tell physicians where to practice, who to treat and how to treat them, but the time is not now. I hope I will not have to decide about practicing medicine under such conditions.

Worthy W. McKinney MD

W. W. McKINNEY, M. D., *President*

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EDITORIALS

FREE CLINIC

Publication of the article, "The Free Clinic Movement Enters West Virginia," appearing on page 10 might be considered controversial by some of our readers inasmuch as it contains criticisms of the system of medical care advocated by most of our readers. The article does appear to contribute something, however, to an understanding of how certain of our critics see things and would have things. It, as well, affords us an opportunity to comment on these matters.

Several references are made to the purpose of reform of the medical care system by those involved in "free clinic" movement. We have a more or less proprietary interest in the present system and hence a responsibility to examine any proposals for reform or any proffered alternate system.

We find it difficult to assess the value or utility of such a clinic in Monongalia County which shows no particular shortage of either physicians or sources of medical care. We are at a loss, however, to suggest an area of need with such a ready source of volunteer subjects as a university medical center with its supply of compassionate faculty, unburdened by the rigors of a busy practice, and eager students, after years of taking, overburdened with the need to start giving. Our only conclusion is that in West Virginia, at least, the only possible site for such a medical experiment is in a place where it is probably not needed.

We can understand the University's reluctance to sponsor the clinic for it would be, indeed, an indictment of the University to admit the existence of significant numbers of patients without care in their vicinity when Morgantown has long been a target of criticism as a site for a medical center because of its relative dearth of clinical material. It seems likely that the problem of those patients of the clinic is lack of concern, lack of transportation (which we understand is being rapidly corrected at government expense in Morgantown), or lack of any real need to see a doctor (we note that no real point is made in the article of what was actually treated).

What is presented is a method of providing care—not one we particularly recommend but, nevertheless, a method. Although referred to in the title as *free*, the clinics, we must point out, are free only to the extent that the services provided there are voluntary. It is not free to whatever extent money, from whatever source, is applied there. If the source be charitable, then there is some cost to another charitable enterprise which might have been an alternate recipient of the same charitable fund. If the source be taxes, the cost is to the taxpayer, or assuming the taxes would have been collected in any case, to another program funded by the Treasury source.

We admire the candor of the author in reporting the chaotic circumstances attendant to the meeting of the "National Free Clinic Council." We are impressed with the assessment of motivation of free clinic volunteers as an "ego-trip" on

their part. We take note of and deplore the quality of care, referred to as "Band-aid medicine," dispensed at free clinics. We agree that attendance at such clinics should be a valuable educational experience for students.

We invite further comments from our readers.

LABILITY OF SYSTEMIC ARTERICAL BLOOD PRESSURE

There are individuals who may show a sharp increase in systolic blood pressure when subjected to a brief period of excitement. This may be noted, for example, when the blood pressure is taken in a physical examination for life insurance in the physician's office. As a rule the rise in blood pressure is fleeting and returns to normal levels in a relatively short time. This phenomenon may occur in young individuals.

The question arises whether such an individual whose blood pressure is so labile is more likely than another to develop essential hypertension in later life. A number of workers in recent years have suggested that excessive variability of systolic blood pressure is an intermediate stage in the development of sustained elevated blood pressure. The medical literature is not very helpful concerning this matter for no objective evidence has been offered that this actually occurs. A great deal of more research work is needed on this problem.

Recently observations on variability of systolic blood pressure in normotensive rats have been reported which may have some bearing on the problem under discussion. In essence, daily systolic blood pressures were obtained for approximately three months on normotensive and spontaneously hypertensive rats (the latter were procured by inter-breeding rats which exhibited above the average blood pressure). It was determined that an empiric dividing line for hypertension in the rat was a systolic pressure of 150 mm. Hg. It was observed that 11 of the 40 control rats showed at times an average weekly pressure above the level of the usually accepted controls. These rats were regarded as "borderline hypertensives."

The data procured by these authors[1] actually provided the first objective evidence that animals with "borderline hypertension" have a greater lability of blood pressure than their normotensive counterpart. The authors are continuing to follow the surviving animals to learn whether the "borderline hypertensives" of the control group will ultimately convert to permanent hypertension.

It is unfortunate that the diastolic pressure could not have been recorded, but with the method the authors used this could not be done. It would be of interest to repeat the work on larger mammals, such as dogs (incidentally, there are hypertensive dogs). Observations should of course be made on man. This would be a long study, for careful clinical records on many hundreds of patients who can be followed for a few decades would be required to answer the clinical question. Such a study would be eminently worthwhile for the entire problem is of great importance. If borderline hypertension is detected, particularly in a young individual, his blood pressure should be determined periodically, and if the pressure, especially the diastolic, shows a sustained elevation proper therapeutic measures should be adopted.

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[1]Frohlich, E. D., et al. Proc. Soc. Exp. Biol. Med. 140: 145, 1972.

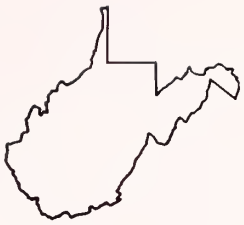
Farewell to Fahrenheit

Effective January next, all AMA publications will list patients' temperatures in centigrade (they prefer to call it Celsius) degrees. Thus the normal temperature will be 37. Those of us who were graduated from medical school before 1940 (or maybe 1950) will have some difficulty in reacting to a nurse's report that the patient's temperature is now 39.5 We'll have to look (perhaps surreptitiously) at a conversion table to find out how sick he is. Actually it's 103.1. And in an AMA publication, the article will simply say that the temperature is 39.5 and no nonsense about adding 103.1 in parentheses. Presumably, glass graduates will have to be calibrated in milliliters, not ounces. And they won't accept cubic centimeter either, because a milliliter is not one cubic centimeter, but rather 1.00003 cubic centimeters. (That's right: four zeros after the decimal point.)

The basic unit, the meter, was once defined as a ten millionth of a meridional quadrant of the earth. Refined measurements soon indicated that this was somewhat in error, so the present definition of a meter is 1650763.73 wave lengths in vacuum of the radiation corresponding to the transition between the levels $2p_{10}$ and $5d_5$ of the krypton 86 atom. See how easy it is! Even the gram, strictly speaking, should be the millikilogram which, though it sounds like a thousandth of a thousand grams, is apparently different.

The spectrum of usable drugs, if you are so old-fashion as to use the apothecary's system, is from 1/150th of a grain to 5 grains, with one grain nicely in the middle. The same values in the new system will be from 0.0004 to 0.3 Gram which, it seems to us, invites error in counting the number of zeros. Time was when you spoke of a grain of medicine, a grain of gold, and even a grain of common sense. But we must not stall the wheels of progress.—*Journal of Medical Society of New Jersey.*

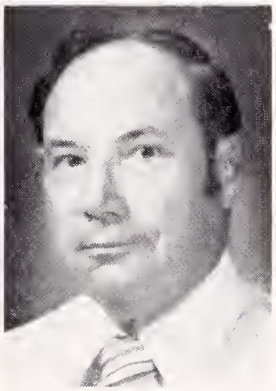
GENERAL NEWS



Clinical Conference Program Assumes Final Form

Surgical and medical treatment of arthritis — diabetes in children — cancer of the colon and breast — problem-oriented records — heart disease — pneumoconiosis — chronic bronchitis in coal miners — lung scans — pulmonary angiography.

George H. Khoury, M. D.



Robert L. Jackson, M. D.

These are key areas in which papers and discussions will be centered as 10 societies, organizations, etc., join in sponsorship of an expanded Mid-Winter Clinical Conference at Charleston's Heart-O-Town Motor Inn Saturday and Sunday, January 20 and 21.

With only scattered exceptions, the program for the Conference was complete as this issue of *The Journal* went to press. The two-day offering will be the first in what the State Medical Association's Committee on Medical Education and Hospitals, in particular, hopes will develop into a major annual postgraduate training opportunity.

Saturday Morning Agenda

Dr. Allen H. MacKenzie, an internist and rheumatologist from Cleveland, Ohio Clinic, will be the featured speaker at the 10 A.M. session on Saturday, January 20, as the subject matter deals with surgical and medical treatment of arthritis. Dr. J. Hugh Wiley, Morgantown orthopedic surgeon, will preside and a panel of other practicing orthopedists from several West Virginia cities also will have program roles.

At the 12 noon recess, at least two of the organizations joining in sponsorship of the two-day Conference—the West Virginia Diabetes Association and the West Virginia Thoracic Society—will have luncheons and annual business meetings.

Saturday Afternoon Program

At 2 P.M., Dr. Robert L. Jackson, Professor and Chairman of Pediatrics at the University of Missouri's School of Medicine, will speak on "Diabetes in Children," a subject in which he has conducted internationally recognized study and research.

Papers on cancer of the breast and cancer of the colon will follow at 3 P.M. by Drs. J. Shelton Horsley, III, of the University of Virginia in Charlottesville and Harry E. Bacon of Philadelphia, respectively. The papers will be followed by a discussion period to continue until a 5 P.M. adjournment.

Doctor Horsley is Clinical Director, Division of Cancer Studies; Professor of Surgery; Director, McIntire Tumor Clinic; Clinical Cancer Coordinator, and American Cancer Society Professor of Clinical Oncology at the University of Virginia Medical Center.

Doctor Bacon is Professor, Colon and Rectal Surgery, at St. Luke's and Childrens Medical Center in Philadelphia, and Emeritus Professor of Colon and Rectal Surgery, Temple University Health Sciences Center.

Sunday Morning Topics

A 9 A.M. program on Sunday, January 21, will include a discussion of problem-oriented records by Dr. A. K. Pfister of Charleston and a discussion of new projects of the American Society of Internal Medicine by Dr. Leo H. T. Bernstein of Martinsburg, President of the West Virginia Chapter of the ASIM.

At 10 A.M., Drs. George H. Khoury and Robert J. Marshall, both of West Virginia University in Morgantown, will speak on "Congenital Heart Disease in the Neonate—Problems and Management," and "Pulmonary Hypertension and Heart Disease," respectively.

Doctor Khoury is a Professor in Pediatrics and Director of Pediatric Cardiology at the WVU Medical Center, where Doctor Marshall is a Professor of Medicine.

The Sunday morning program will be followed by a buffet luncheon at noon.

Sunday Afternoon Program

Two additional WVU staff members—Dr. N. Leroy Lapp and Dr. Edwin J. Morgan—will lead off the Sunday afternoon program at 1:30 with discussions of "Respiratory Impairment in the Simple Pneumoconiosis" and "Chronic Bronchitis in Coal Miners," respectively.

Doctor Lapp is an Associate Professor of Medicine at the West Virginia University School of Medicine and Chief, Medical Research Branch, Appalachian Laboratory for Occupational Respiratory Diseases

(ALFORD). Doctor Morgan, Assistant Professor of Medicine at the WVU Medical Center, is Chief of the Clinical Section, Medical Research Branch, for ALFORD.

Dr. Steven A. Artz of Charleston will speak on "The Clinical Value of Lung Scans" at 2:30 P.M. on Sunday, with Dr. James K. Sexton of Charleston to discuss "Pulmonary Angiography" at 3 P.M. The Conference will move toward final adjournment at approximately 4 P.M.

Doctor Artz, a specialist in internal medicine and endocrinology, is a graduate of the State University of New York College of Medicine in Syracuse and he was Chief Resident, Endocrine Service, at Montefiore Hospital in New York City in 1966.

Doctor Sexton is a radiologist, and a graduate of Wake Forest University's Bowman Gray School of Medicine in Winston-Salem, North Carolina.

Other Conference Details

Additional presiding officers for the Conference will include Dr. Alvin L. Watne, Professor of Surgery at the WVU School of Medicine, on Saturday afternoon; Dr. Harold Selinger, Charleston cardiologist and President of thee West Virginia Heart Association, on Sunday morning and Dr. Charles E. Andrews, Provost of Health Sciences at WVU, on Sunday afternoon.

The complete list of Conference sponsors, in addition to the State Medical Association, includes the Association's Section on Orthopedic Surgery; West Virginia Chapter of the Arthritis Foundation; West Virginia Diabetes Association; West Virginia Division, American Cancer Society; West Virginia Thoracic Society; West Virginia Tuberculosis and Respiratory Disease Association; West Virginia Heart Association; the WVU Medical Center, and the West Virginia Chapter, American Society of Internal Medicine.

The Conference registration fee of $15 will include the Sunday buffet luncheon, and will be charged all registrants except nurses, medical students, interns and residents.

Physicians are encouraged to register in advance, and may use forms mailed to them earlier or that which appears on page 15 of this issue of *The Journal*. The forms should be mailed to West Virginia State Medical Association, P. O. Box 1031, Charleston 25324.

PG Courses at Cleveland Clinic

Two postgraduate programs will be held in January and February at the Cleveland Clinic Educational Foundation.

Scheduled for January 17 and 18 is "Managing the Complicated Surgical Patient," followed by "Medical Progress for the Family Physician," January 31 and February 1. The registration fee for the first course is $60; the fee for the latter, $45.

"Medical Progress for the Family Physician" is acceptable for 12 credit hours.

Applications and fees should be mailed to: The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44106.

State Physicians Active Participants In AMA Clinical Convention

A large number of West Virginia physicians attended the 26th Annual Clinical Convention of the American Medical Association which was held in Cincinnati, November 26-29.

C. A. Hoffman, M. D.

Richard W. Corbitt, M. D.

Dr. Carl A. Hoffman of Huntington, who is at the mid-way point in his term as President of the AMA, called upon the Association to play a key role in solving some of the major problems facing the nation in the field of health care for its citizens. He placed particular emphasis upon the need of protection for Americans from financial ruin due to catastrophic illness, and the maldistribution of physicians as it affects the inner city and rural areas.

Doctor Hoffman said that the United States appears to be deficient in insurance coverage for catastrophic illness but that "no one in this affluent nation should suffer financial deprivation or bankruptcy because of serious illness or accident."

For complete coverage of the AMA Clinical Convention see the December 4 issue of the American Medical News.

The AMA President also suggested several possible solutions in re the maldistribution of physicians and how these young men and women might be encouraged through a "strictly voluntary" program to practice in the rural and inner city areas where there is a desperate need for physicians and other health care personnel.

Dr. Corbitt Named Committee Chairman

Another West Virginia physician, Dr. Richard W. Corbitt of Parkersburg, also played an important role during the Convention as Chairman of the Program Committee for the 14th National Conference on the Medical Aspects of Sports.

Doctor Corbitt, a Past President of the State Medical Association, also was honored by being named to serve as Chairman of the key six-man AMA Committee on the Medical Aspects of Sports, effective January 1.

More than 400 physicians, coaches, managers and athletes attended the two-day sports session which

was highlighted by a resume of the preparations and participation by medical personnel during the Olympic Games in Munich, Germany.

In addition to Drs. Hoffman and Corbitt, the meeting was attended by Drs. Frank J. Holroyd of Princeton and Richard E. Flood of Weirton, AMA Delegates; and Drs. George R. Callender, Jr., of Charleston, and Harry S. Weeks, Jr., of Wheeling, Alternate Delegates. Other officers of the State Medical Association in attendance were Drs. Worthy W. McKinney of Beckley, President; A. Thomas McCoy of Charleston, President Elect; William E. Gilmore of Parkersburg, Vice President; and Kenneth G. MacDonald of Charleston, Treasurer.

U. S. Cancer Scientists Visit Russia

Seven American cancer scientists went to Russia and for two weeks exchanged information on cancer viruses with leading Soviet scientists in the U.S.S.R. The exchange was part of the U.S.-U.S.S.R. health agreement to share research results from cancer, heart disease and environmental studies which was signed in Moscow in May, 1972, during President Nixon's summit meeting.

As part of the exchange agreement, the U. S. scientific delegation will present to Soviet scientists 31 strains of cancer viruses affecting chickens, cats, rodents, and nonhuman primates, as well as a possible human tumor virus from a muscle cancer. James F. Holland, M. D., a specialist in treating cancer by drugs, has been named to work in the Soviet Union for one year to help carry out the new U.S.-U.S.S.R. program.

Looking Back 10 Years . . .

Speakers at the annual meeting of The West Virginia Chapter, American College of Surgeons, at The Greenbrier April 18-20, 1963, included Dr. William B. Kiesewetter, left, Surgeon-in-Chief, Children's Hospital, Pittsburgh, and Dr. H. William Clatworthy, Jr., Chief of the Department of Pediatric Surgery at Children's Hospital in Columbus, Ohio.

Medical Education Coordinator Recommended At WVU

The West Virginia Joint Council on Teaching Hospitals has recommended establishment of a position at the West Virginia University School of Medicine to coordinate medical education programs, particularly at the graduate and postgraduate levels, in the State.

The action came at the Joint Council's Annual Meeting in Parkersburg on November 16 and generally reflected a similar position taken earlier by the Council's Executive Committee.

In other action, the Joint Council:

—Reelected Dr. David Z. Morgan, Associate Dean of the WVU School of Medicine in Morgantown, and Administrator David C. Schmauss of Beckley Appalachian Regional Hospital to its Executive Committee for one-year terms.

—Elected Mr. Custer B. Holliday, the State Medical Association's Executive Assistant, as Secretary-Treasurer to succeed Mr. Charles R. Lewis, whom Mr. Holliday replaced in the Medical Association post after Mr. Lewis' resignation.

—Granted Council membership to the Veterans Administration Center in Martinsburg and Huntington Hospital, Inc., in Huntington.

—Amended its Constitution and By-Laws to extend voting privileges to associate members—those hospitals which do not operate internship and/or residency programs.

'I Am Joe's Heart'

"I Am Joe's Heart," a television program for patients' viewing, will be shown Sunday, January 7 at 7:30 p. m. on Huntington's Channel 13 (WHTN-TV) and on Sunday, January 11 at 10:30 P. M. on Pittsburgh's Channel 11 (WHC-TV).

The new TV special tells about the heart, its function, its needs, and the effects that various abuses have on it. It will supply information on how to minimize the risk of heart attacks and give insight into healthier daily living patterns that everyone—including cardiac patients—should adopt.

Endorsed by the American Heart Association, the program is being sponsored by the Burroughs Wellcome Co. as a public service.

Medical Ethics Congress in April

Dr. Walter H. Judd, Chairman of the Judicial Council, AMA, cordially invites West Virginia Association members to attend the Fourth National Congress on Medical Ethics, to be held April 26-28, at the Washington Hilton in Washington, D. C.

Among the subjects to be discussed will be: "What Is Medical Ethics?," "How Does the Student or the Resident or the Nurse See Medical Ethics?," "The Teaching of Medical Ethics," "Medical Ethics and the New Biology," and "Voluntarism vs. Compulsion."

New Director Appointed By Heart Association

Appointment of a new Executive Director for the West Virginia Heart Association has been announced by Mrs. Seth Savage of Vienna, Chairman of the Board. He is Mr. Charles E. Sikorski of Wilmington, Delaware, who will assume his new duties the middle of December.

Charles E. Sikorski

Mr. Sikorski has been Executive Director of the Mental Health Association, Inc., for the past three years. Prior to that he was Associate Director of the Wisconsin Heart Association and a National Field Representative for the American Cancer Society.

He was educated at Marquette University, where he received a degree in Business Administration, and has completed several courses in continuing education, especially in the health agency field. During his residence in Wilmington, he has been active in civic and community affairs, including youth and health service activities.

Mr. Sikorski, his wife and two children, ages three and seven, will reside at 31 Hillsdale Circle, Scott Depot, West Virginia.

Until the new executive assumes his duties, the post will be filled by an acting director, Mrs. Frank Harris, of Kenova.

Mr. Sikorski succeeds Mr. Richard Bates, who resigned.

Doctor Hoffman Honored By Missouri College

Drury College in Springfield, Missouri, conferred an honorary doctor of science degree upon Dr. C. A. (Carl) Hoffman of Huntington as it marked its 100th anniversary on November 16.

Doctor Hoffman, President of the American Medical Association, also was the keynote speaker fer the observance and stressed the need for combined efforts to resolve current problems in the medical care delivery system.

"We . . . believe that no American should be denied access to medical care for financial reasons, and that no family should be saddled with the high cost of catastrophic illness or accident," Doctor Hoffman said, and he then added:

"The government's role in this should be to provide some kind of health insurance protection for those Americans who are unable to pay . . . but whatever emerges from Congress should also be carefully designed to preserve the vitality and freedom of a private care medical system that has made American Medicine the finest in the world in terms of quality."

Significant Number of Persons Malnourished, Survey Shows

In December of 1967, Congress directed the Department of Health, Education, and Welfare to conduct a comprehensive survey to determine the prevalence of malnutrition and related health problems in this country. West Virginia was selected as one of the 10 states (plus New York City) to be included in the National Nutrition Survey, funded through the Health Services and Mental Health Administration of DHEW.

Although the survey in West Virginia was conducted in the Summer and Fall of 1969, the analyzed and tabulated data from the survey was only recently made available to the West Virginia Department of Health, reports Dr. N. H. Dyer, State Director of Health. The final report of the National Nutrition Survey also was released recently.

The National Nutrition Survey provided five types of data: general demographic, dietary intake, clinical and anthropometric, dental and biochemical. These surveys placed greatest emphasis on obtaining information from the low income segments of the population, that is, primarily those in the lowest quartile of average income according to 1960 census data. However, the survey was not restricted to low income families.

In West Virginia, 48 per cent of households surveyed were considered to be below the poverty level.

The final report of the 10-State Nutrition Survey indicates that a significant proportion of the population surveyed was malnourished or was at a high risk of developing nutritional problems. The report indicates that there was considerable variation in severity and types of nutritional problems in different segments of the population studied. Generally there was increasing evidence of malnutrition as income level decreased.

The Survey showed that adolescents between the ages of 10 and 16 years had the highest prevalence of unsatisfactory nutritional status, according to Doctor Dyer. The data in West Virginia showed that trend. Male adolescents showed more evidence of malnutrition than did females. Elderly persons also showed evidence of increased nutritional deficiencies.

Dental health was mentioned as one of the most prevalent health problems encountered. The poor eating habits of the adolescents, particularly regarding between-meal snacks, gives reason for concern because of the relationship between concentrated sweets and dental disease.

Iron deficiency anemia, as evidenced by a high prevalence of low levels of hemoglobin, was shown to be a widespread problem in the population included in the 10-State Nutrtiton Survey. Adolescent and adult males showed an unexpectedly high incidence of low hemoglobin levels. This trend was evident in the data obtained in the West Virginia Nutrition Survey, says Doctor Dyer.

There was evidence of retarded growth and development in the population studied, with a trend

to greater growth retardation in the low-income-ratio states.

Vitamin A nutrition appeared to be a problem in a large proportion of the population included in the 10-State Nutrition Survey. This was a major problem in the Spanish-Americans included in the Survey, but young people in all subgroups had a high prevalence of low Vitamin A levels. Dietary intake data indicated inadequate consumption of foods which are good sources of this essential nutrient.

Some of the more significant findings of the 10-State Nutrition Survey have been discussed. What can be done to alleviate these problems? What is being done? Various agencies and programs in West Virginia are attempting to use this data in a constructive manner. Nutritionists from the State Department of Health are counseling health workers and families regarding the need for improved eating patterns, particularly with regard to Vitamin A and iron-rich foods. Personnel in child caring facilities are receiving increased consultation from nutritionists regarding the feeding program in these centers.

Also cooperating in the better nutrition effort are the Early Childhood Development Program of the West Virginia Department of Health, the West Virginia Commission on Aging, the Department of Education, the Cooperative Extension Service, and the West Virginia Department of Welfare, which administers the Food Stamp Program.

Dr. Lattimer Stoneburner Lecturer At Medical College of Virginia

John K. Lattimer, M. D., will be the Stoneburner Lecturer at the Stoneburner Lecture Series February 22-23 at the Medical College of Virginia in Richmond.

Doctor Lattimer was a guest speaker at the Centennial Meeting of the West Virginia State Medical Association in 1967. He is Professor and Chairman, Department of Urology, College of Physicians and Surgeons of Columbia University, New York.

His topics will include "The Comparison of the Assassinations of President Lincoln and President Kennedy," "Carcinoma of the Prostate; The Great Widow Maker," and "The Optimum Treatment for Undescended Testes."

The Stoneburner Lecture Series is a postgraduate course in "Clinical Adult and Pediatric Urology." It is sponsored by the Department of Continuing Education at MCV in conjunction with the Mid-Atlantic Section of the American Urological Association.

The program is acceptable for 11 prescribed hours by the American Academy of Family Physicians.

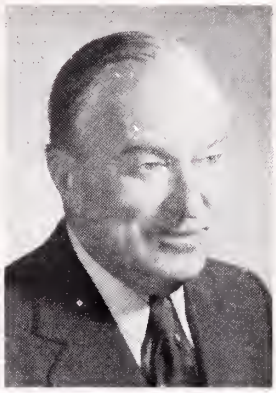
The fee is $55 for the course, including registration, social hour and banquet. Banquet tickets will be available for wives and guests at $15 per person.

Registration may be made with the medical college at Box 91—MCV Station, Richmond, Virginia 23219. Checks should be made payable to: Department of Continuing Medical Education—Medical College of Virginia.

Doctor Duckwall Elected Member Of Publication Committee

Dr. Vernon E. Duckwall of Elkins was elected a member of the Publication Committee at the Fall Meeting of the Council in Charleston.

Doctor Duckwall succeeds Dr. Halvard Wanger of Shepherdstown for the term ending December 31, 1979. Doctor Wanger had served as a member of the Committee for the past 10 years.


Vernon E. Duckwall, M. D.

As a member of the Publication Committee, Doctor Duckwall will serve as an Associate Editor of *The West Virginia Medical Journal.*

A native of Van (Wert County), Ohio, Doctor Duckwall received a B.S. degree in economics from the University of Pennsylvania and was employed in that field for the next seven years. He then decided upon a career in medicine and received his M. D. degree in 1941 from the Columbia University College of Physicians and Surgeons.

He interned and served a residency at the New York Postgraduate Hospital in New York City and served for three years as a Major in the Medical Corps of the United States Army during World War II.

Doctor Duckwall was certified by the American Board of Surgery in 1951 and has practiced his specialty in Elkins since that time. Active in the affairs of organized medicine, he is a past president of the Tygart's Valley Medical Society and has served as treasurer since 1968.

'Norwalk Agent'

Government scientists believe they have found the cause of intestinal flu, the ailment that frequently sweeps through a community or an office causing 24 to 48 hours of nausea, vomiting, diarrhea and abdominal cramps in its victims.

They call it "Norwalk agent."

Doctors have generally called the disease acute infectious nonbacterial gastroenteritis because a specific cause had not been identifiable. The ailment is not to be confused with the sometimes deadly influenza which occasionally causes international epidemics.

Scientific investigators for the National Institutes of Allergy and Infectious Diseases, working from a 1968 outbreak of the disease in Norwalk, Ohio, and using the latest techniques in scientific photography, claim to have captured the elusive "Norwalk agent" on film.

Two Physicians To Serve In 61st Legislature

Two doctors of medicine will serve as members of the West Virginia Legislature during the 61st session when the House and Senate convene at The Capitol in Charleston on January 10.

David E. Wallace, M. D.

Roy A. Edwards, M. D.

Dr. David E. Wallace of Madison, a Democrat, has completed two years of a four-year term as a member of the State Senate from the 7th District, made up of Lincoln, Boone and Logan counties. He served as Chairman of the Senate Health Committee and also was a member of the key Committee on the Judiciary.

Dr. Roy A. Edwards, Jr., a Huntington psychiatrist and a Republican, was elected to one of Cabell County's six seats in the House of Delegates for a two-year term. Also elected to the House of Delegates were the following wives of West Virginia physicians: Mrs. Charles W. Merritt of Beckley, a Democrat whose husband is a specialist in the field of obstetrics and gynecology; and Mrs. J. A. B. Holt, a Republican whose husband is an EENT specialist in Charleston.

Mrs. Merritt served as a member of the 60th Legislature and was successful in her bid for re-election to a second term in November. Mrs. Holt will be serving her first term as a member of the House of Delegates.

Doctor Wallace is a native of Van in Boone County and received a Bachelor of Science degree in Biology from Morris Harvey College in Charleston in 1958. He was graduated from the West Virginia University School of Medicine in 1963, interned at Charleston Memorial Hospital and has been engaged in general practice in Boone County since 1964.

Doctor Edwards is a native of Huntington and was graduated from Marshall University in 1942. He served with the United States Army during World War II and received his M. D. degree in 1948 from the Medical College of Virginia.

He interned and served residencies at the Medical College of Virginia Hospitals, 1948-53, and served for several years as a member of the staff at the Western State Hospital in Hopkinsville, Kentucky. He has practiced his specialty of psychiatry in Huntington since 1956 and is currently serving as Chairman of the State Medical Association's Committee on Mental Health.

Report on Health Care Issued By General Accounting Office

The General Accounting Office, Congress' watchdog on federal spending, issued a voluminous report on the nation's health care system with recommendations that it estimated could save several billions of dollars annually.

The basic recommendations were for better construction, design and planning, better usage of health care facilities, and more emphasis on preventive medicine and group practice.

The year-long GAO study was commissioned by Congress originality to survey the Hill-Burton hospital construction program. The Senate Labor and Public Welfare Committee later asked the GAO to expand it to include all aspects of health care.

Reduction of hospital stays and more emphasis on out-patient treatment are essential, the GAO said. It was recognized that the health insurance coverage of out-of-hospital care has been increased, but the GAO said that "a large number of people still lack this coverage because they cannot afford to spend more money on health insurance." The American Medical Association, Blue Cross and Blue Shield were reported as favoring further increases in outpatient coverage.

One out of four patients was reported to receive more hospital care than necessary. The report said that reducing hospital stays an average of one day would in effect add 96,000 beds to the nation's hospitals. It was estimated that putting patients needing long-term care, as opposed to acute, in special facilities would not only be less expensive but would make available 126,000 beds in general hospitals. Expansion of home health care programs would reduce the need for 20,000 hospital beds the report said. Sharing of services by regional groups of hospitals could increase efficiency. For example, the 90,000 hospital beds allotted to obstetrics could be reduced by 38,000.

The report also said sharing of services also could cut demand for new hospital facilities for such procedures as open-heart surgery, radiation therapy and kidney dialysis. The GAO investigators found that of 416 hospitals equipped to do open-heart surgery in 1969, 97 per cent used them less than four times a week. Pediatric and emergency services also offer sharing possibilities, the study said.

The study concluded that alternate health-care systems such as prepaid group practice, foundations for medical care and health maintenance organizations "may offer significant savings." The report said that such groups generally use at least 20 per cent fewer hospital days per 1,000 patients than traditional care.

106th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

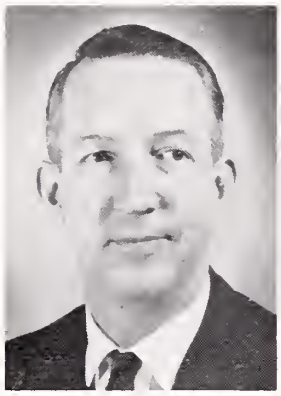
AUGUST 22-25, 1973

PLAN NOW TO ATTEND

Dr. David Morgan Appointed Associate Dean at WVU

Dr. David Z. Morgan, a native of Fairmont and a member of the West Virginia University School of Medicine faculty for eight years, has been appointed Associate Dean of that school.

Increasing administrative responsibilities in the School of Medicine were cited by Dean Frank W. McKee in discussing Doctor Morgan's new position.



David Z. Morgan, M. D.

"Generally expanding internal demands and the more widespread extramural involvement of the medical school have made it necessary to have more than one person who can assume responsibility and speak knowledgeably about the school," he said.

Doctor Morgan, Assistant Dean since 1966, will continue to serve as Adviser in Student Affairs. He will have increasing intramural responsibilities relative to University Hospital and extramural duties concerned with continuing education, according to Dean McKee.

"The promotion recognizes Doctor Morgan's proficiency both as a teacher and an administrator," Dean McKee added. "It will give him expanded outlets for his capabilities."

Doctor Morgan holds two degrees from WVU: an A. B. received in 1948 and a B. S. from the School of Medicine in 1950. His M. D. was granted by the Medical College of Virginia in 1952.

Completing his internship at Ohio Valley General Hospital in Wheeling and a residency at WVU Medical Center, Dr. Morgan was certified by the Board of Internal Medicine in 1964, the same year he joined the School of Medicine faculty. He was promoted to associate professor in 1969.

Doctor Morgan is a Navy veteran and a member of many state and national professional groups, including the American College of Physicians. He is a board member of the West Virginia Heart Association and Chairman of the Council of the Monongalia County Tuberculosis and Respiratory Disease Association.

He has also served as Chairman of the West Virginia Joint Council on Teaching Hospitals, Secretary and President of the Monongalia County Medical Association and President of the WVU School of Medicine Alumni Association.

In 1972, he was recognized as the Outstanding Clinician of the School of Medicine, an award voted annually by the senior medical class.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Jan. 20-21—6th Mid-Winter Clinical Conf., Charleston.
Jan. 21-24—Soc. of Thoracic Surg., Houston.
Jan. 26-28—Sou. Rad. Conf., Point Clear, Ala.
Feb. 2-7—Am. Acad. of Orth. Surg., Las Vegas, Nev.
Feb. 8-10—Southeast. Surg. Cong., New Orleans.
Feb. 10-14—Am. Acad. of Allergy, Washington.
Feb. 14-18—Am. Col. of Cardiology, San Francisco.

March 29-30—AMA Nat. Conf. on Rural Health, Dallas.

April 2-4—ACS (Spring), New York City.
April 2-7—Am. Col. of Rad., San Francisco.
April 6-7—Am. Otol. Soc., St. Louis.
April 6-8—W. Va. Chapter, AAFP, Morgantown.
April 6-8—Am. Soc. Int. Med., Chicago.
April 7-12—Am. Col. of Allergists, Atlanta.
April 8-12—Am. Assn. of Neu. Surg., Los Angeles.
April 8-13—ACP, Chicago.
April 16-18—Am. Assn. for Thoracic Surgery, Dallas.
April 18-21—W. Va. Academy of Ophth. and Otol., White Sulphur Springs.
April 23-28—Am. Acad. of Neurology, Boston.
April 25-27—Maryland Medical, Baltimore.
April 25-27—Am. Surg. Assn., Los Angeles.
April 29-May 2—Am. Soc. for Head and Neck Surgery, Hot Springs, Va.

May 2-5—ACS, W. Va. Chapter, White Sulphur Springs.
May 2-5—Am. Gyn. Soc., Colorado Springs, Colo.
May 5—W. Va. Soc. of Anesth., Morgantown.
May 7-9—Am. Col. of Sports Med., Seattle.
May 7-11—Am. Psych. Assn., Honolulu.
May 13-17—Am. Urol. Assn., New York City.
May 16-20—Am. Ped. Soc., San Francisco.
May 20-23—Nat. TB & RD Assn., New York City.
May 21-24—Am. Col. of Ob. & Gyn., Bal Harbour, Fla.
May 21-24—Am. Thoracic Soc., New York City.
May 28-30—Am. Ophth. Society, Hot Springs, Va.

June 22-23—Am. Diabetes Assn., Chicago.
June 24-27—Am. Assn. of Plastic Surgeons.
June 24-28—AMA, New York City.

Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.
Sept. 18-20—Ky. Medical, Louisville.
Sept. 28-Oct. 4—AAFP, Denver.

Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.

Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.
Dec. 1-5—AMA Clinical, Anaheim, Calif.
Dec. 1-6—Am. Acad. of Derm. Chicago.

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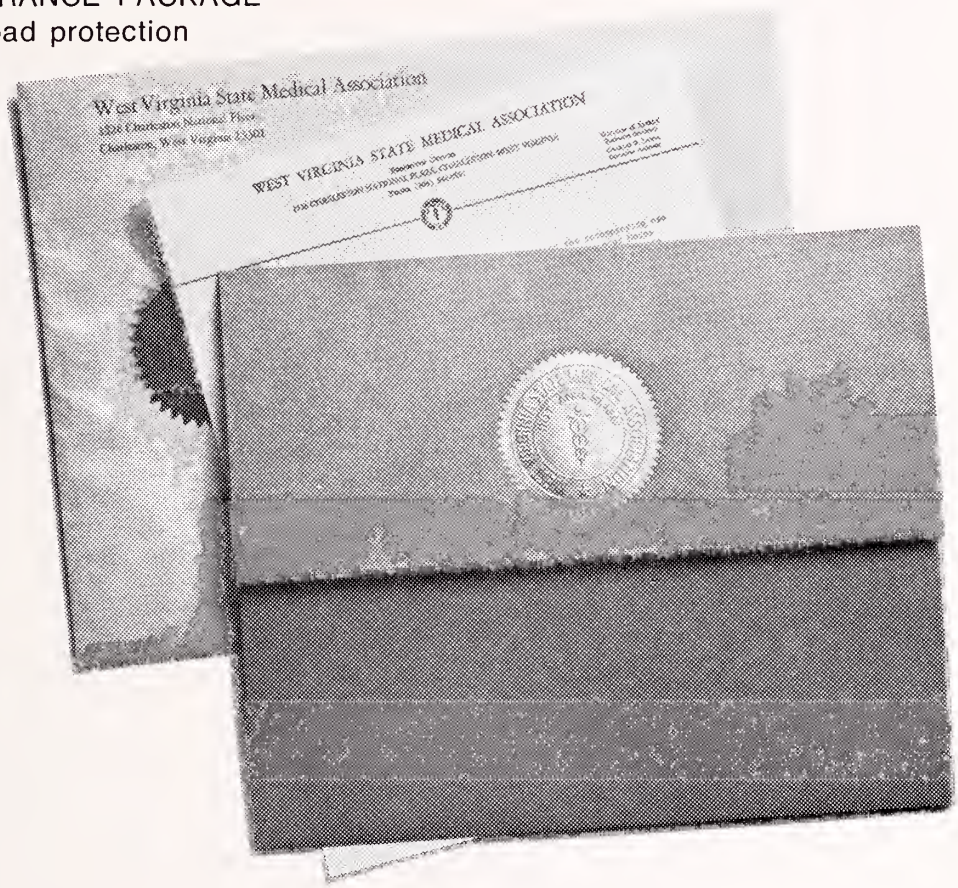

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WVU Medical Center
—News—

ONCOLOGY, internal medicine's newly recognized subspecialty, derives its name from the Greek words "onkos"—meaning mass or bulk or, in medicine, tumor—and "logos"—meaning word. Medical dictionaries describe it as the study or science of neoplastic growth.

Raymond B. Weiss, M. D.

Physicians who specialize in Oncology, and there are fewer than 500 of them in the United States, are bringing new insights and successes to the management and treatment of cancer.

West Virginia's first Oncologist is Dr. Raymond B. Weiss, who in mid-October joined the West Virginia University School of Medicine faculty as Assistant Professor in the Department of Medicine.

At WVU, Doctor Weiss will develop the Oncology teaching program for medical students, interns and residents. He will also aid in the care of cancer patients at University Hospital and provide consultative services to practicing physicians throughout West Virginia.

The field of Oncology has developed steadily during the past 25 years, but the greatest strides have been made in the past 10 years with the advent of training programs like the one Doctor Weiss completed recently as a U. S. Public Health Service-supported Fellow in Medical Oncology at University of Minnesota Hospitals in Minneapolis.

Doctor Weiss is a graduate of the University of Minnesota and its Medical School. He first came to West Virginia in 1965 for an internship at University Hospital, beginning his residency in medicine there the following year. He served from 1967 to 1969 as an Army medical officer, and then returned to WVU for the second year of his residency in medicine before entering the Oncology training program at Minnesota in 1970.

Last February, Medical Oncology was officially recognized as a subspecialty by the American Board of Internal Medicine, of which Doctor Weiss became a Diplomate in 1971. Certification examinations soon will be offered similar to those now in existence for other medical subspecialties such as Cardiology, Gastroenterology and Allergy.

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

Neurosurgeons at WVU

Two neurosurgeons recently joined the West Virginia University Medical Center staff and WVU President James G. Harlow has announced their appointments. Both Assistant Professors in the School of Medicine's Department of Surgery, they are Dr. William M. Chadduck and Dr. Ira C. Denton, Jr.

Doctor Chadduck, a native of Washington, D. C., was graduated from Yale University and earned both a master's degree in Physiology and his medical degree in 1962 from the University of Virginia. He was elected to Alpha Omega Alpha honor medcal society, held a National Institutes of Health Fellowship in Physiology, and received another fellowship in 1961 for study at the Institute for Experimental Surgery in Copenhagen, Denmark.

During the five years of postgraduate training in his specialty at Virginia, Doctor Chadduck was recipient of a NIH Fellowship in Neuropathology and a Southern Medical Association Fellowship in Neurosurgery. A Board certified neurosurgeon, he has had extensive military, group and hospital practice experience and is author or co-author of scientific articles on such subjects as procedures for control of intractable pain.

Recipient this past year of the coveted Von Wagenen Fellowship awarded annually by the American Association of Neurological Surgeons for outstanding work by a resident, Doctor Denton recently completed six months of study in Zurich, Switzerland, with Dr. M. Gazi Yasargil, the world's most famous microneurosurgeon. He has also done research on prostaglandins and their effect on the cerebral blood vessels.

Doctor Denton was born in Memphis, Tennessee. He was graduated cum laude from Vanderbilt University. After his graduation from the University of Tennessee School of Medicine in 1963, he spent six months as a research associate at the Karolinska Institute's Department of Immunochemistry in Stockholm, Sweden, and then served an internship at Boston, Massachusetts, City Hospital. He received his training in General Surgery at the University of Minnesota, where he won the Resident Teaching Award, and in Neurosurgery at the University of Tennessee's Semmes Murphey Clinic.

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James A. Gardner, M. D.

Orthopedics
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S. A. Zahir, M. D.
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Obstetrics-Gynecology
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Warren D. Elliott, M. D.
Owen C. Meadows, M. D.
Robert P. Pulliam, M. D.
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Ophthalmology
Edward T. Liu, M. D.

Urology
S. L. Francis, M. D.

Internal Medicine
Preston C. Davis, M. D.
Joseph A. Maiolo, M. D.
Jose L. Oyco, M. D.
Eugene Warvariv, M. D.
R. James Yates, M. D.

Pediatrics
P. B. Gogo, M. D.
R. G. D. Concepcion, M. D.

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George K. White
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The Month in Washington

• From the Washington Office of the American Medical Association.

CONGRESSIONAL leaders have given national health insurance a high priority, but the new Congress convening this month may not act on it until late this year or even next year. Senate Democratic Leader Mike Mansfield of Montana assigned the legislation "the highest priority" and expressed confidence that a national health insurance program will be approved during the next two years by the 93rd Congress.

The key congressman on this legislation, Rep. Wilbur D. Mills (D., Ark.), Chairman of the House Ways and Means Committee, has described the 93rd Congress as moving "to fashion a national health insurance program which the great bulk of Americans can support."

The three major national health insurance bills before the Congress will be the Nixon Administration's proposal financed by employer-employee contributions, the American Medical Association's Medicredit plan and legislation sponsored by Sen. Edward M. Kennedy (D.-Mass.).

The Ways and Means Committee acts first on such legislation and it had been expected to take up tax reform and possibly pension plan legislation before national health insurance. This would have deferred national health insurance for at least several months. But the timetable has not been definitely set and Mills recently indicated that tax reform might be given a lower priority.

Health Maintenance Organizations

Another piece of legislation of major importance to the medical profession that will be before the 93rd Congress deals with health maintenance organizations (HMOs). The Senate last year approved a bill authorizing a broad HMO program and the House Health Subcommittee approved a much more limited program.

Democrats remain in control of Congress and the key congressmen on health care legislation will continue to be Mills; Kennedy, Chairman of the Senate Health Subcommittee; Rep. Paul G. Rogers (D.-Fla.), Chairman of the House Health Subcommittee; and Sen. Russell B. Long (D.-La.).

Both the Ways and Means Committee and the Senate Finance Committee held extensive hearings on national health insurance during the 92nd Congress but the legislative process must start anew because all pending bills die automatically at the end of a two-year Congress.

Medicredit, slated for early introduction, is being expanded to include home care and limited dental benefits. In the 92nd Congress, Medicredit had 174 sponsors, by far the largest number for any national health insurance legislation.

Kennedy Plan Most Expensive

Kennedy, with the support of organized labor, sponsored the most costly plan in the 92nd Congress. It also called for extensive reorganization of the nation's health care delivery system with the government having a dominant role. At this writing, he had not disclosed any details of his new bill.

He and Mills have conferred on national health legislation to see if they could agree on a program. In a recent speech, Kennedy said that Mills "and I plan to jointly introduce such legislation early next year (1973)." But Mills has not gone quite this far, at least in his public statements. Last fall Mills said of his talks on the matter with Kennedy:

"We found wide areas of agreement. But obviously there were key areas where we did not—particularly in the financing and administrative areas. It may be that as we continue to discuss these areas further agreement can be made. I think I will be able to convince him that reliance on the federal treasury and the federal bureaucrat is not the best way to accomplish our common objectives."

Proposed Restricting Sales of Barbiturates

The Bureau of Narcotics and Dangerous Drugs has proposed restricting sales of nine barbiturates which were described as highly addictive and linked to 1,771 suicides and deaths in 17 months.

The Bureau said the barbiturates are more dangerous than heroin.

"Withdrawal from the use of these drugs can be fatal and, in many instances, withdrawal symptoms are more severe from a barbiturate habit than from heroin addiction," BNDD Director John E. Ingersoll said.

He identified the barbiturates by their generic names as amobarbital, butabarbital, cyclobarbital, heptabarbital, pentobarbital, probarbital, secobarbital, talbutal and vinbarbital. He listed only five brand-name drugs: seconal (secobarbital), tuinal (amobarbital and secobarbital), amytol (amobarbital), neumbutal (pentobarbital) and butisol (butabarbital).

The BNDD Director asked the Food and Drug Administration to place the nine barbiturates under the same controls for cocaine, morphine, codeine, methadone and amphetamine.

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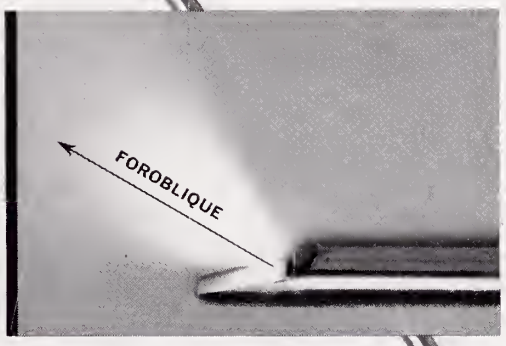

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Obituaries

FRANK V. LANGFITT, M. D.

Dr. Frank V. Langfitt of Clarksburg, who was active in the affairs of organized medicine for more than 50 years and a Past President of the West Virginia State Medical Association, died at a hospital in Clarksburg on December 3, 1972. He was 89.

Frank V. Langfitt, M. D.

A native of Morgansville (Doddridge County), Doctor Langfitt attended Salem College, West Virginia Wesleyan College and West Virginia University. He received his M. D. degree in 1907 from the University of Maryland School of Medicine and served a one-year internship at the Maryland General Hospital before entering general practice at Salem in 1908.

Doctor Langfitt served as a First Lieutenant in the Medical Corps of the United States Army during World War I and returned to Baltimore in 1919 where he served a residency in surgery at St. Agnes' Hospital. In June of 1920, he returned to West Virginia where he practiced his specialty of surgery until his retirement several years ago.

He served as Secretary and President of the Harrison County Medical Society and was elected President of the State Medical Association in 1940. At the time of his death, he continued to serve actively as a member of the Association's key Committee on Legislation.

He was a Fellow of the American College of Surgeons and was one of the founders and served as President of the Monongahela Valley Hospital-Surgical Association. He also was active in community affairs and served as an officer and member of the boards of several business firms. Doctor Langfitt served as a member of the Area Advisory Council of Salem College and in 1960 received an honorary Doctor of Humanities degree from that college.

He is survived by his widow; a daughter, Mrs. James H. (June) Brewster, Jr., of Weston; two sons, Frank V. Langfitt, Jr., of Portland, Oregon, and Dr. Thomas W. Langfitt of Philadelphia, Professor and Chairman of the Department of Neurosurgery at the University of Pennsylvania School of Medicine. Also surviving are 13 grandchildren and three great-grandchildren.

(Continued on Page xx)

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OBITUARIES—(Continued)

CLEMENT A. SMITH, M. D.

Dr. Clement A. Smith, Morgantown radiologist, died in University Hospital there November 22. He was 58.

A native of Schenectady, New York, Doctor Smith was a graduate of Union College in New York and the Albany Medical College. He interned at Albany Hospital and served a radiology residency at Roosevelt Hospital in New York City.

A Major in the U. S. Army's Medical Corps in 1942-46, Doctor Smith was Associate Professor of Radiology at Albany Medical College until 1948 and then was Chief, Department of Radiology, at Roosevelt Hospital before moving to Morgantown in 1952.

He was a member of Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association, and was certified by the American Board of Radiology in 1942.

Doctor Smith is survived by his widow; two sons, C. Arthur Smith of North Amity, Maine, and Guy Michael Smith of Keswick, Virginia; a daughter, Mrs. Haydn Jones of Morgantown; a brother, J. Vincent Smith of Schenectady, and a sister, Mrs. Lauman Martin of Skaneateles, New York.

* * * *

EVERETT W. SQUIRE, M. D.

Dr. Everett W. Squire, a Charleston radiologist, died November 29 at the Memorial Hospital Division, Charleston Area Medical Center, Inc. He was 60.

Doctor Squire was a native of Aberdeen, South Dakota; and a graduate of Northwestern University in Evanston, Illinois, and Rush Medical College in Chicago.

He interned at Mercy Hospital in Des Moines, received a master's degree in Radiology from the University of Minnesota, and also did postgraduate work in Radiology at the Mayo Clinic in Rochester, Minnesota.

A Fellow of the American College of Radiology, he was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Squire is survived by his widow; two sons, Richard H. Squire of Cincinnati, Ohio, and Douglas L. Squire of Philadelphia; three sisters, Miss Ione Squire of Tucson, Arizona; Mrs. John Eyestone of Aberdeen and Mrs. G. W. Wynn, Wheeling, and three brothers, Dr. F. H. Squire and Carroll Squire, both of Yuma Valley, California, and K. P. Squire, Aberdeen.

* * * *

ERNEST M. WILKINSON, M. D.

Dr. Ernest M. Wilkinson of Pineville (Wyoming County) died December 4 at his home. He was 73.

A native of McKenney, Virginia, Doctor Wilkinson was educated at Hampden-Sydney College and received his M. D. degree in 1923 from the Medical College of Virginia.

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Thoracic Surgery:
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Stephen D. Ward, M. D.
David H. Smith, M. D.
Robert L. Mendelson, Ed D.

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J. N. Aceta, M. D.

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Brenda Muklewicz, R. N.
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Juanita Stone, R. N.
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Evelyn Forester, R. T.

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Henry L. Castilow, Asst. Mgr.

Doctor Wilkinson had practiced in Pineville since 1935 and operated the Pineville Maternity Hospital from 1954 to 1966. He started his practice at Dante, Virginia in 1924, and also practiced in Welch before moving to Pineville.

He was a member of the Wyoming County Medical Society, the West Virginia State Medical Association, the Virginia Medical Association, the Southern Medical Association and the American Medical Association. He also was a member of the Pineville Rotary Club.

Survivors include his widow; two sons, Ernest M. Wilkinson, Jr., of Covington, Virginia, and Richard Warren Wilkinson of Bluefield; two brothers, Richard and David Wilkinson of McKenney; three sisters, Mrs. James Williams of McKenney, Mrs. Mary Jane Harris of Richmond, Virginia, and Mrs. Henry Rogers of Welch.

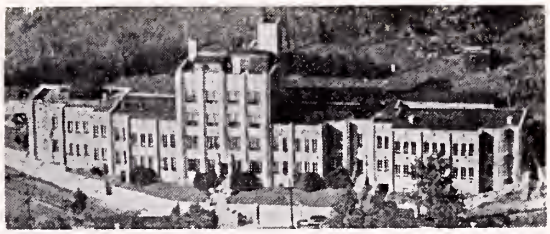
* * * *

ARNOLD WILSON, M. D.

Dr. Arnold Wilson, formerly of Welch, died No-67, and had retired in 1967 after practicing in Pasadena for 26 years.

A native of Quinton, Alabama, Doctor Wilson was a former member of the medical staff of Grace Hospital, now Doctors Memorial Hospital, in Welch. He held medical degrees from the University of Alabama and the University of Chicago.

He was a former member of the McDowell County Medical Society and the West Virginia State Medical Association.



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County Societies

CABELL

The basketball program at Marshall University was described by Bob Daniels, head basketball coach, at the November 9 meeting of the Cabell County Medical Society at Huntington's Hotel Frederick. Athletic Director Joseph McMullen also made brief remarks.

The Society adopted its Nominating Committee's report listing these new officers: Dr. Thomas F. Scott, President; Dr. E. J. Humphrey, III, President-Elect; Dr. Gerald E. Vanston, Vice President; Dr. William S. Sadler, Treasurer; and Dr. Charles H. McKown, Jr., Secretary.

Dr. Samuel Biern, Jr., spoke on the progress he's making to secure federal funds for treatment and prevention of drug addiction in the Huntington area.—G. E. Vanston, M. D., Secretary.

* * * *

MERCER

Dr. J. Elliott Blaydes, Jr., presented a program on cataract surgery at the meeting of the Mercer County Medical Society November 20 at the West Virginian Hotel in Bluefield.

Dr. Karl E. Weier reported on the Comprehensive Health Care Planning Program. The Society unanimously passed a motion endorsing the agency. A motion expressing gratitude to Drs. David Bell, Karl Weier, L. J. Pace and others for their efforts in achieving the formation of the Compreshensive Health Care program also was approved.

The following officers were elected: Drs. A. J. Paine, President; Hawey A. Wells, Vice President; and John J. Mahood, Secretary-Treasurer. Named as Delegates to the West Virginia State Medical Association were Drs. David Bell, L. J. Pace, Sam Milchin and Frank J. Holroyd; and Alternates, Drs. Henry Warden, Upshur Higginbotham, R. O. Rogers and J. Elliott Blaydes.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

An interesting and provocative talk on "Philosophical Reflections on Mental Death" was given by William S. Hamond, Ph. D., Professor of Philosophy at West Virginia University, at a meeting of the Monongalia County Medical Society November 7 at Lakeview Inn and Country Club.

Doctor Nottingham, the Society's representative on the Information Committee of the Monongalia County Comprehensive Health Planning Association, reported on activities of the committee. During his presentation it was pointed out by Drs. Pride and Wiles that any projects planned to provide health care services must be approved by the Regional and State Health Planning Committees to obtain any federal funds for the project.—Hubert T. Marshall, M. D., Secretary.

* * * *

TYGART'S VALLEY

A program on "Renal Transplants" was presented by Dr. Schrae LaPlante at the meeting of the Tygart's Valley Medical Society on November 16 at the Elks Country Club in Elkins. Doctor LaPlante is Assistant Professor of General and Vascular Surgery at the West Virginia University Medical Center.

The Society voted that the President should be a candidate for election to the Board of Directors of the West Virginia Medical Service, Inc.

New Officers elected for 1973 were: Dr. Samuel M. Santibanez, President; Dr. Robert R. Rector, First Vice President; Dr. Ernest G. Guy, Second Vice President; Dr. Vernon E. Duckwall, Treasurer, and Dr. T. H. Chang, Delegate to the West Virginia State Medical Association.—A. Kyle Bush, M. D., Secretary.

AMA Executive Discusses Advertising In Scientific Publications

Dr. W. R. Barclay, Assistant Executive Vice President of the American Medical Association, said that the AMA reserves the right to reject drug advertising even if it conforms to Food and Drug Administration regulations.

He said the AMA had accepted the FDA's authority as to drug advertising when it was promulgated in 1968 "after determining that the regulations would provide adequate screening and furthermore would have the advantage of being consistently applied to all medical publications, not just AMA journals."

Doctor Barclay added, however, the AMA reserved the further right of rejection, not only as to drugs but to other products too, "if the proposed ad is judged to be in poor taste, if the layout would cause confusion with the editorial content of *The Journal* or if the ad is for a product, service or book which is not covered by FDA regulations and which in AMA's opinion does not meet our standards of acceptability."

"Ads placed in scientific journals reach a well educated, well informed and broadly experienced audience that has access to many sources of scientific information. Since all material in such ads has been judged by FDA to be correct and accurate it is difficult to see how such advertisements could adversely affect prescribing practices.

"In spite of the plethora of information available to physicians, the AMA has developed and distributed without charge to its members its own evaluation of drug products. This book is titled *AMA Drug Evaluations;* unfortunately, we are in no better a position to judge the impact of this book than we are to judge the impact of advertising or editorial copy in our journals."

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Medical Journal

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69 No. 2

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ultimate prospects of success
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pful adjunct to your counseling,
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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1973

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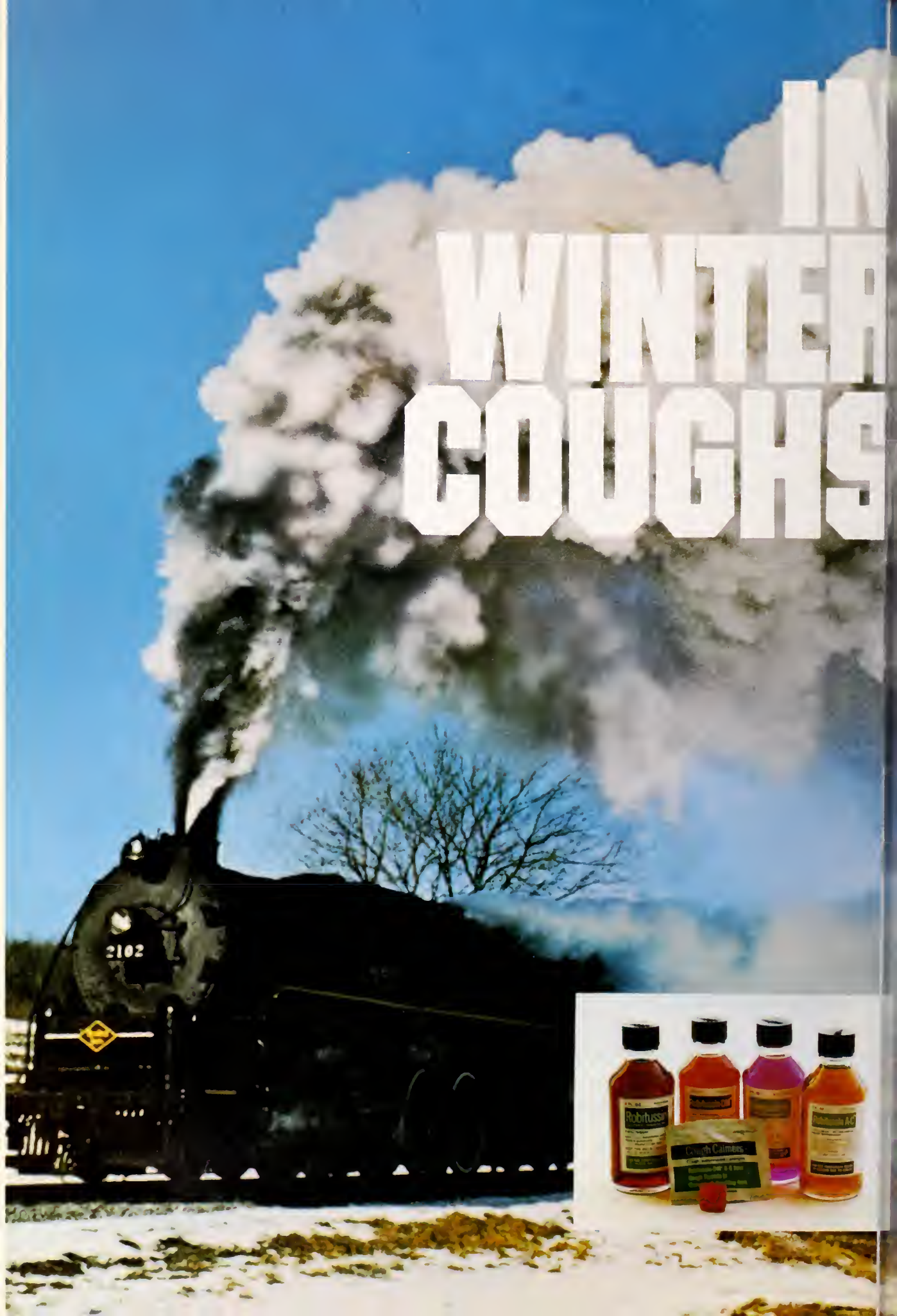
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Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

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The West Virginia Medical Journal

Vol. 69, No. 2 February, 1973

Treatment of Post Intubation and Cuffed Tube Tracheal Stenosis with T-Tube Tracheal Stent

Anthony J. Oliverio, M. D., and Philip M. Sprinkle, M. D.

Much has been written about the increased incidence and etiology of tracheal stenosis following the use of a cuffed tube and assisted ventilation[1,2]. Many methods of repairing these injuries have been reported. These include simple methods of tracheal dilatation, excision of stricture, end-to-end anastomosis and staged reconstructive procedures utilizing skin flaps.

Montgomery[4], in 1965, reported the use of a T-tube tracheal stent in repair of tracheal injuries and reported a case of using a silicone T-tube for correction of post-tracheostomy tracheomalacia in a four and one-half-month-old infant. Fishman[5] et al. reported the case of a T-tube stent after circumferential resection of a stenosis when tracheomalacia occurred. The stent was left in place for one year. When attempting to remove it, complete obstruction occurred because of granulation tissue. No further attempt was made to decannulate the patient. Johnson et al[6] reported a series of 12 cases of tracheal stenosis managed conservatively either by repeated dilatation or by placing a fenestrated Portex tube through the stricture. In three of these four cases, the result was satisfactory but he had only very short follow-up periods since removal of the stents.

Three cases are reported with repair of tracheal stenosis secondary to cuffed tracheostomy tubes by use of silicone stents with follow-up visits for over a year.

Case Reports

Case 1.—E.S., a 48-year-old white female, was admitted to West Virginia University Hospital on July 4, 1970, with increased respiratory distress over 24 hours. The patient was in severe respiratory distress with sternal and intercostal retractions. A chest x-ray revealed a diffuse interstitial infiltrate involving all of the segments of both lungs. A diagnosis of acute interstitial alveolitis was made and the patient was immediately intubated and placed on an Emerson respirator. She was placed on antibiotics and steroids. The endotracheal tube was left in place for three days. On July 7, 1970, a tracheostomy was performed in routine manner under local anesthesia and the patient remained on assisted ventilation. On July 11, 1970, an acute abdomen developed and an exploratory laparotomy was carried out for perforated duodenal ulcer. The tracheostomy tube was removed nine days later. The patient was discharged on July 30, 1970, and was followed in the Outpatient Department by the Medicine Chest service.

The Authors

- **Anthony J. Oliverio, M. D., and Philip M. Sprinkle, M. D., Division of Otolaryngology, West Virginia University School of Medicine, Morgantown.**

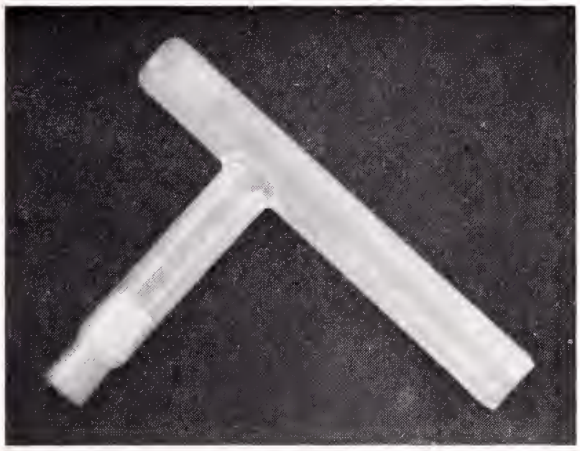

Figure 1. T-Tube Tracheal Stent (actual size).

One month later, when seen in the Outpatient Clinic, she complained of dyspnea on exertion and was found to have palpable stridor in the area of the previous tracheostomy scar.

She was admitted to the hospital and bronchoscoped, and a tracheal stenosis which would just admit a six mm. bronchoscope was found. This stenosis was below the tracheostomy site (three cm. above the carina). Under local anesthesia, the trachea was entered by a midline incision down to and transverse to the tracheal stenosis. A T-tube stent was inserted.

Five months later, the tracheal stent was removed. Bronchoscopy revealed no residual stenosis or granulation tissue. The patient is doing well after two and one-half years of follow-up.

Case 2.—P.C., was admitted to West Virginia University Medical Center on April 11, 1969, with a flail chest. A tracheostomy was performed and a number eight cuffed tracheostomy tube inserted. The patient was placed on a respirator for three weeks and subsequently decannulated and discharged. Two months later he became cyanotic, with marked stridor and a history of gradual onset of dyspnea. A bronchoscopy was immediately performed and a three by three mm. stricture, five cm. distal to the chords, was found. A forty by eight mm. scope could not be passed and the stricture was dilated to a number 30 French. The patient was dilated on several occasions subsequently but re-strictured in two weeks. The old tracheostomy incision was excised and a new tracheostomy was performed, a 12 mm. silastic T-tube stent placed, and the incision closed. The stent was removed in three months.

One month afterward, dyspnea and stridor developed. He became progressively worse and was readmitted on October 28, 1969. A bronchoscopy was performed and a tracheal stenosis three cm. in length was found five to six cm. below the cords. On November 3, the patient was taken to the operating room and the old scar excised. The stenotic area was identified at the level of the sixth tracheal ring; the anterior tracheal wall was split, the stenotic area excised and a silicone T-tube tracheal stent placed. The stent was left in place for nine months and removed. The patient has been followed in the outpatient clinic since that time. We saw him one year later and the only complaint at that time was mild, exertional dypsnea. He is still doing well.

Case 3.—R. J., a 52-year-old female, sustained facial and chest injuries. She was admitted on June 1, 1971. The patient was placed on a ventilator for 15 days. A tracheostomy had been performed on the day of admission and the tube plugged and removed two days later. Two weeks after decannulation, dyspnea and severe intercostal retractions and wheezing developed. A bronchoscopy was performed and an area of stenosis beneath the tracheostomy scar was found with a three mm. opening. An emergency tracheostomy was performed and the patient had immediate relief of distress.

On July 7, 1971, the trachea was opened, the area of stenosis resected, and a T-tube stent placed.

A bilateral pneumothorax developed postoperatively and chest tubes were removed four days later.

On July 15, 1971, a bronchoscopy was performed because of respiratory distress and mucus plugs were suctioned from the level of the carina and left main stem bronchus. The patient continued to have mild respiratory distress and on July 19 it became severe. A number four bronchoscope was passed through the stent and a stenotic area found below the stent would barely pass a number four bronchoscope. The T-tube stent was removed and a number six by sixty-eight trach tube inserted through the stenotic area, with immediate relief of airway obstruction. A silicone stent was then placed over the end of the number six tracheostomy tube and through the stenotic area. This was done on August 1, 1971, and the stent left in place for a period of nine months at the end of which time it was removed. The patient has had no airway problem since removal of the stent (in April, 1971). A bronchosopy performed on February 15, 1972, revealed no area of stenosis and a number eight bronchoscope could be passed with ease. The patient has had no further airway problems.

Summary

In the three cases reported, prolonged stenting after excision of stenosis and scar tissue has provided satisfactory end results. All three of these patients now have adequate airways and are able to function normally. In the third case, in spite of the problems of stenosis below the original stent, adequate airway was eventually obtained by placing the silicone stent over a tracheostomy tube and leaving it in place for nine months.

It is felt that prolonged stenting is an adequate method of treating severe tracheal stenosis and, thus, more radical procedures may be avoided.

A list of references may be obtained by writing The Journal.

The Anterior Interosseous Nerve Syndrome*

(Case Report and Review of the Literature)

Ludwig Gutmann, M. D.; Robert K. Hobbs, M. D.; and James H. Wiley, M. D.

It is difficult to be exact but some 30-40 cases of anterior interosseous nerve syndrome have been reported to date. Parsonage and Turner[1] are credited with the first report in 1948 in conjunction with shoulder girdle paralysis from various causes. Kiloh and Nevin[2] reported two cases in 1952 and some authors now call it the Kiloh-Nevin syndrome.[3] Many others have reported cases and the largest collection appears to be 10 patients presented by Spinner[4] in 1970.

In most of the cases the onset was spontaneous but some have been reported in conjunction with forearm[5] and supracondylar[6] fractures. Many of these recovered spontaneously in a few weeks but most did not and the ones which were explored were found to have constricting fibrous bands across the anterior interosseous nerve. Release of these bands allowed prompt recovery.

Description and Anatomy

The anterior interosseous nerve syndrome is characterized by loss of function of the flexor pollicus longus, pronator quadratus and flexor digitorum profundus to the index and sometimes to the middle finger. There are no associated sensory changes and the attitude of pinch is characteristic (Figure 1).

Normally, the median nerve lies on the surface of the brachialis muscle medial to the biceps tendon and brachial artery and passes into the forearm deep to the lacertus fibrosus between the ulnar and humeral heads of the pronator teres. On emerging from this muscle it passes between the two heads of the flexor digitorum superficialis and runs deep to it distally into the wrist. The anterior interosseous nerve is the largest branch of the median nerve and is strictly motor in function arising some two to eight cm. distal to the level of the medial epicondyle, averaging about five cm. It runs distally on the flexor digitorum profundus and then passes between it and the flexor pollicis longus along the interosseous membrane behind the pronator quadratus. In its course multiple branches are given off early to the flexor pollicis longus and the radial portion of the flexor digitorum profundus. A large terminal branch supplies the pronator quadratus.

It is obvious that, in order to produce the syndrome, the entire anterior interosseous nerve must be involved and this can only occur near its point of origin from the median nerve.

Case Report

A 19-year-old white female student was first seen because of an ingrown toenail which was surgically corrected. One month later she complained of mild pain in the antecubital area of her right arm and inability to flex the distal joint of her right index finger. There were no other positive physical findings at that time in the cervical spine, shoulder, elbows, wrists or hands. X-rays were unremarkable. Six weeks later she was again examined and found to have complete loss of function of the flexor pollicis

The Authors

- **Ludwig Gutmann, M. D., Professor and Chairman, Department of Neurology; Robert K. Hobbs, M. D., Resident, Division of Orthopedic Surgery; and James H. Wiley, M. D., Associate Clinical Professor of Orthopedic Surgery; all at the West Virginia University Medical Center, Morgantown.**

Figure 1. The characteristic attitude of pinch is here demonstrated in the right hand (left side of picture) and the normal attitude is demonstrated in the left hand. Note the inability to flex the distal interphalangeal joints of the thumb and index finger.

***Presented by Robert K. Hobbs, M. D., at a meeting of the Section on Orthopedic Surgery during the West Virginia State Medical Association's 105th Annual Meeting August 23-26, 1972, at The Greenbrier in White Sulphur Springs.**

longus and the flexor digitorum profundus to the index finger. There was thought to be only slight pronator quadratus weakness. EMG confirmed the diagnosis showing the main trunk of the median nerve to be normal but the flexor pollicis longus and flexor digitorum profundus showed marked denervation and no motor unit potentials under voluntary control.

There was no return of function and exploration of the right median and anterior interosseous nerves was carried out eight weeks after the onset of symptoms. She was found to have a glistening white constricting fibrous band arising from the flexor digitorum superficialis muscle crossing both the median nerve and the anterior interosseous nerve near its point of origin (Figure 2). This band was released along with filmy perineural adhesions and 12 weeks later return of function was noted with rapid progressive return of good pinch strength.

Figure 2. The probe is beneath the main trunk of the median nerve and the anterior interosseous nerve can be seen below. The glistening white fibrous bank crosses both nerves diagonally in the right side of the wound. The elbow is to the left side of the picture.

Discussion

The history and findings in this case were typical of many previously reported cases. The attitude of the hand on attempting to pinch the thumb and index fingertips is very characteristic and as constant as hand attitudes for other well-known peripheral nerve lesions.

Spinner[4] recommends that spontaneous anterior interosseous nerve paralysis should first be treated by non-surgical means because in many cases there is a spontaneous return to normal function. If there is no clinical or electromyographic return in six to eight weeks then the nerve should be explored.

There is an interesting corollary syndrome involving the posterior interosseous nerve as reviewed by Bryan[7] et al characterized by lack of extension of the fingers and usually caused by a constricting fibrous arcade across the nerve. In the case which they reported there was no return of function 10 months after release of the fibrous band and others have also reported poor results.

Summary

A case report of anterior interosseous nerve paralysis is given which was relieved by release of a constricting fibrous band. A short review of the literature and description of the posterior interosseous nerve syndrome are also presented.

A list of references may be obtained by writing The Journal.

Microscopic Fibers and Cancer

National Cancer Institute scientists have reported laboratory animal studies that indicate size, not chemical composition, of various microscopic fibers is the primary cause of some lung cancer. According to the National Society for Medical Research, Dr. Mearl F. Stanton of the Institute's Laboratory of Pathology reported his work at a recent conference in Lyon, France.

The series of experiments with rats was carried out to determine the ability of various fibrous and non-fibrous substances to cause cancer of the pleura, the membrane surrounding the lungs. Results showed that very fine fibers of asbestos, glass or sapphire caused a high incidence of pleural cancer in animals. Coarse fibers or powdered material of the same compositions only rarely caused cancer.

Doctor Stanton and his associates found that the cancer-causing fibers were between one-half and five microns in diameter (about one-hundredth as thick as an eyelash) and less than 80 microns long.

NIC officials point out that human mesotheliomas, cancers of the membranes lining the lungs and abdomen, occur primarily among individuals exposed to asbestos dust.

106th ANNUAL MEETING

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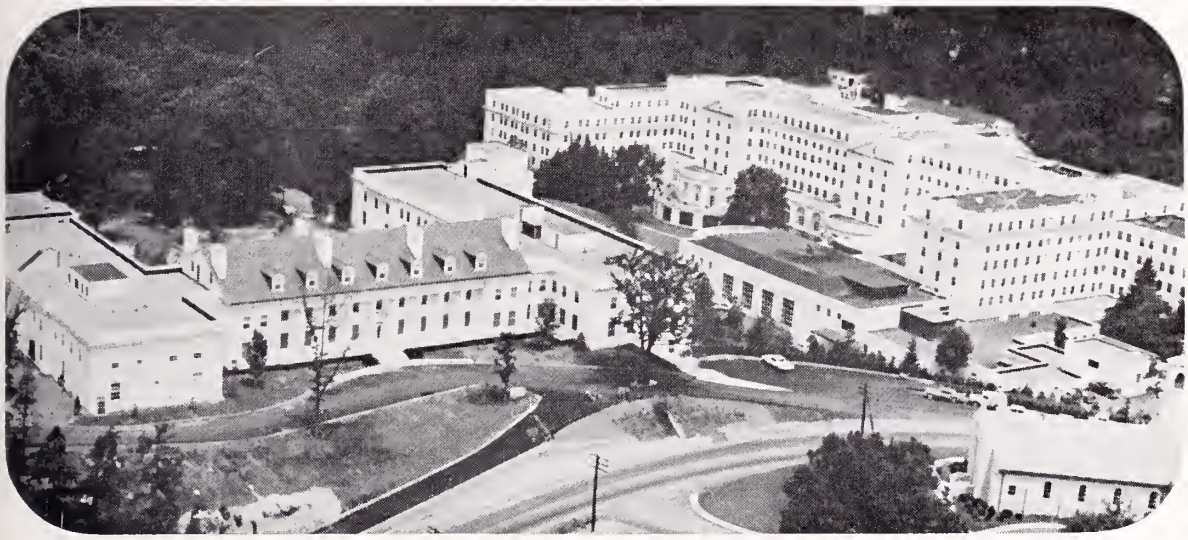

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The Diagnostic Value of Ventricular Volume Measurements*

Richard J. Bouchard, M. D.

Recognition of the relationship between cardiac enlargement and heart disease is centuries old. Although standard chest roentgenographs are helpful in verifying cardiac enlargement, they do not differentiate hypertrophy from dilatation nor do they elucidate dynamic phenomena. Cardiac catheterization and angiography have facilitated assessment of the contracting human heart better enabling the physician to recognize and manage impaired ventricular function.

Techniques

The two most commonly used methods for determination of left venticular volume are the angiographic and thermodilution techniques.

Angiographic Methods

Angiographic methods involve the injection of radiographic contrast medium into the left atrium or left ventricle with subsequent exposure of single plane or biplane conventional x-ray film (at 3-12 frames per second) or cine filming of the fluoroscopic image (at 50-200 frames per second). Plain films provide somewhat clearer images with sharper borders. Cineangiograms permit more thorough dynamic analysis of the cardiac cycle. For biplane film analysis the shape of the left ventricular cavity is usually assumed to approximate an ellipsoid of revolution. Thus, left ventricular cavity volume is obtained from the formula:

$$\text{Volume} = 4/3\ \pi \times \frac{L}{2} \times \frac{D_{AP}}{2} \times \frac{D_{Lat}}{2}$$

in which L = the longest measured diameter, D_{AP} = the transverse diameter in the anteroposterior plane and D_{Lat} = the transverse diameter in the lateral plane. The minor axes, D_{AP} and D_{Lat}, are derived from the planimetered area and the corresponding long axis in each plane.

The difference between volumes at end diastole (EDV) and at end systole (ESV) represents the stroke volume (SV). The normal left ventricular EDV is 70+20 m/(S. D.) per square meter of body surface area. SV/EDV (ejection fraction) reflects the capacity of the ventricle to empty and is a useful index of ventricular functions; its value in normal patients is 0.67± .08 (means ± S.D.).

Thermodilution

This technique is based upon the indicator dilution principle. A small amount of a cold substance (usually saline or autologous blood) is injected into a cardiac chamber. Minute temperature changes are detected with a thermistor on a catheter tip placed immediately downstream. A step function decremental temperature curve is inscribed, with each plateau corresponding to a single cardiac cycle. The ratio ESV/EDV is described by the formula:

$$ESV/EDV = C_n/C_{n-1}$$

in which Cn and C (n-1) represent temperatures at sequential steps down the decay curve. When SV is known (from Fick, dye-dilution, or thermodilution cardiac output determinations divided by heart rate) absolute values for ESV and EDV can be calculated.

Thermodilution volumes can be measured repetitively with small amounts of an innocuous injectate. Since no specific geometric model is assumed, volumes of cardiac chambers which deviate from the ellipsoidal shape can be evaluated. However, the method is not accurate in the presence of atrio-ventricular valvular valve regurgitation.

Hypertonic contrast material used in angiographic procedures exerts transient depressant effects upon the myocardium and may alter hemodynamics. Therefore, serial volume determinations are inadvisable. The method is valid, however, in the presence of valvular regurgitant lesions.

Non-Invasive Techniques Useful In Assessment of Ventricular Volume

To avoid the need for cardiac catheterization and to permit less invasive assessment of ventricular volume, methods for measuring ventri-

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*Provided by the West Virginia Heart Association.

cular volume using peripheral venous injections of radioisotopic substances with precordial scanning are currently being developed. Determination of left ventricular volumes and ejection fraction by echocardiography has recently been described. Current studies are exploring correlations between systolic time intervals and left ventricular volumes assessed independently. These intervals are obtained by non-invasive techniques requiring only the simultaneous recording of the electrocardiogram, the phonocardiogram and the external carotid pulse wave.

Utility of Ventricular Volume Determinations

Tension and Velocity

Isolated cardiac muscle exhibits two fundamental mechanical properties: (1) tension development and (2) shortening. Tension development is inversely related to instantaneous velocity of shortening. Changes in the contractility of cardiac muscle are reflected by changes in the relationship between shortening velocity and tension development. The theoretical extrapolation of the curve depicting the relationship between tension and velocity to zero force or load provides a theoretical shortening velocity (V_{MAX}) used as an index of contractile state. The force of cardiac muscle contraction can be enhanced by passive stretch, that is, the Frank-Starling mechanism. However, passive stretch does not influence the extrapolated V_{MAX} since contractile state is not changed.

Tension-velocity relations in isolated muscle cannot be simply or directly applied to the ejecting ventricle. However, some insight into the tension-velocity characteristics of the left ventricle may be obtained by analysis of the time course of transverse dimensional changes taken from frame by frame study of high speed cineangiographic silhouettes and corresponding instantaneous wall tension computed from a modification of the La Place relation, that is,

$$\text{tension} = \frac{\text{pressure x radius}}{\text{2 x wall thickness}}$$

Ejection Fraction

The capacity of the heart to pump blood to the peripheral tissues is a reflection of the mechanical properties of cardiac muscle, i.e. the ability of the ventricle to alter its volume during systole. Conventional and useful hemodynamic measurements such as cardiac output, blood pressure and systemic arterio-venous oxygen differences do not provide an estimate of ventricular emptying; however, ejection fraction calculations do. Unfortunately, since ejection fraction calculations do not take into account tension or the velocity of contraction, they do not provide quantitative reflections of contractile state. For example, when mitral regurgitation provides the left ventricle with a low impedance pathway for emptying into the left atrium, the ejection fraction may be normal even when ventricular contractility is depressed. Nevertheless, despite these and other limitations ejection fraction determinations facilitate assessment of ventricular functions.

Assessment of Regurgitant Lesions

Left ventricular volume measurements are helpful in quantifying the severity of regurgitant lesions of the mitral and aortic valves. The regurgitant volume is represented by the difference between the stroke volume determined angiographically and the forward stroke volume (F.S.V.) determined independently by the Fick or indicator dilution methods.

$$\left\{ \text{F.S.V.} = \frac{\text{cardiac output}}{\text{heart rate}} \right\}$$

Such information together with the calculation of valve area by the Gorlin Formula is helpful in determining whether valvular surgery is needed and in selecting the preferred procedure.

Assessment of Ventricular Compliance

Elevation of ventricular end diastolic pressure, long considered indicative of congestive heart failure cannot be interpreted properly without consideration of ventricular volume. Compliance of the ventricle is reflected by the relationship between diastolic filling pressure and the corresponding ventricular volume or, more precisely, the change in pressure associated with a given change in diastolic volume. A compliant ventricle can increase its end diastolic volume without a marked increase in end diastolic pressure. When the ventricle is volume overloaded progressively (for example, with regurgitant valvular lesions or intracardiac shunts), its volume may increase several fold without marked increases in filling pressure and cardiac output may be augmented through the Frank-Starling mechanism.

When volume overload develops suddenly however, such as after papillary muscle rupture, the ventricle cannot increase its compliance acutely, filling pressure rises precipitously and pulmonary edema ensues.

Compliance is often reduced when ventricular hypertrophy follows pressure overload. With idiopathic hypertrophic subaortic stenosis (IHSS) diminished compliance can be demonstrated

frequently even before outflow obstruction has occurred. Compliance may also be profoundly influenced by myocardial fibrosis and aneurysm formation following coronary artery occlusion. Clearly, meaningful interpretations of ventricular filling pressures depend in part on assessment of compliance requiring simultaneous ventricular volume measurements.

Assessment of Ventricular Muscle Mass

The determination of left ventricular muscle mass is a simple extension of the angiographic cavity volume method. The left ventricular free wall thickness is measured from the angiographic image and corrected for non-parallel x-ray beam. Assuming uniform left ventricular wall thickness, this value is added to the previously determined cavitary length and diameters. These dimensions are then substituted in the ellipsoid reference formula and the volume recalculated. The left ventricular muscle mass represents the difference between this recalculated volume and the left ventricular cavity volume. Normal left ventricular muscle mass is 92 + 16 gm/M of body surface area. Muscle mass increases after chronic pressure and volume overloads, particularly the former.

Conclusions

Assessment of left ventricular volumes can be performed by angiographic, thermodilution, radioisotopic, and non-invasive techniques. Volume measurements permit improved assessment of ventricular performance, myocardial contractile state, ventricular compliance, and muscle mass. Furthermore, they are useful in quantification of the magnitude of valvular regurgitation. Accordingly, ventricular volume determinations are playing an increasingly important diagnostic role in clinical cardiology.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Moraxella Endocarditis In A Patient With Systemic Lupus Erythematosus

Paul Huhn, M. D.

An instance of systemic lupus erythematosus in a young woman is reported because of two serious systemic infections which complicated her illness and because she recovered from a crisis precipitated by a Salmonella infection. Typical symptoms and signs of bacterial endocarditis due to an unusual organism, Moraxella kingii, then developed. She recovered from both illnesses completely, but still has active systemic lupus erythematosus which is reasonably well controlled.

Instances of reported bacterial endocarditis superimposed upon Libman-Sacks endocarditis usually are recorded as a post mortem diagnosis. There has been one previously reported case of bacterial endocarditis due to a Moraxella organism. A case of Moraxella endocarditis in a patient with systemic lupus erythematosus and, presumably, Libman-Sacks endocarditis is reported.

The Author

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Case Report

Twenty-one months prior to her present admission, a 21-year-old white female college student presented with a history of fever and swollen, red, painful joints. She gave no history of rheumatic fever. She was found to have splenomegaly, anemia and leukopenia. No heart murmur was heard. The erythrocyte sedimentation rate (ESR) at that time was 96 and two lupus cell preparations were positive. Serum complement level was decreased.

During the next 17 months, she was treated with varying doses of Prednisone and intermittently with nitrogen mustard and 6-Mercaptopurine. Four months prior to this admission, she was found to be febrile and disoriented. A Grade III systolic murmur was heard at the left sternal border. Blood cultures at this time grew out Salmonella. She was treated with Ampicillin two Gm. daily, as well as increased steroids. She improved steadily, but a morbilliform rash developed which was believed due to the Ampicillin. Her fever remitted, and she was discharged with instructions to continue taking Prednisone.

On this admission, she complained of weakness and malaise for two weeks and had more recently suffered fever, chills, joint pains, vomiting, diarrhea, and swelling of both ankles. The pulse was 135 and temperature 40.6° C. She had a Grade III systolic murmur at the apex of her heart radiating to the axilla, and an S-3 gallop. She also had an Osler's node on her left fourth finger and numerous petechiae and splinter hemorrhages. She did not have conjunctivitis. A chest film showed an enlarged cardiac silhouette. The hemoglobin was 11.0 Grams per cent, hematocrit 34 per cent, and a white blood cell count was 3,100 per cu. mm. with 30 per cent bands and 68 per cent neutrophils. Urinalysis showed 20 to 30 red blood cells per high power field and four to five white blood cells per high power field. Six blood cultures grew out gram negative rods which were identified as Moraxella kingii by our laboratory and by the State Department of Health Laboratory.

She was treated with Cephalothin and Kanamycin. During the hospitalization, a substernal chest pain developed and a pericardial friction rub was audible. Left heart failure with pulmonary edema also developed which subsided with Digoxin and diuretic therapy. The heart murmur persisted throughout the hospital stay.

Fortunately, she is still alive and reasonably well two years later. She has lupus nephritis and hypertension, and is being treated with Prednisone, Alpha-methyldopa, and Azathioprine.

Discussion

In the majority of cases, bacterial endocarditis is caused by Streptococus viridans, S. fecalis, and Staphylococcus aureus. A minority of cases are caused by Salmonella, Shigella, Pseudomonas, Klebsiella, and E. coli. One case of Moraxella

endocarditis in a four-year-old boy with a ventricular septal defect has been reported previously.

The usual pathogen of this genera is Moraxella lacunata which produces a chronic or subacute conjunctivitis. This organism in the child was reported as Moraxella New Species I. This probably is the same organism as Moraxella kingii which was reported in our case. Moraxella kingii differs from M. lacunata in that it does not pit Loeffler's media, it ferments glucose and maltose slowly, and it is catalase negative.

Libman-Sacks endocarditis usually is a difficult diagnosis to make ante-mortem. Hurst states that systolic and diastolic murmurs are often heard during life but are difficult to substantiate at autopsy because the size of the lesions is so small. There usually is poor correlation between heart murmurs and endocardial lesions. The incidence of sterile endocarditis varies in different series, but DuBois reports that macroscopic lesions are present in approximately one-third to two-thirds of autopsied cases.

The incidence of bacterial endocarditis superimposed on Libman-Sacks endocarditis is rare. Hejtmancik reports two cases with Staphylococcus aureus endocarditis in a series of 142 cases. Klemperer reports four cases of bacterial endocarditis superimposed on Libman-Sacks endocarditis proven at autopsy. Brigden et al. reported superimposed infections in two cases out of 13 with proven valvular lesions. Griffith reported it in one patient out of eight who had valvular lesions. Burkin likewise reports one case. Harvey reported that 15 patients in a series of 38 autopsied cases of lupus erythematosus died of an infection, but only one of these had bacterial endocarditis.

Du Bois reports that the incidence of vegetations has decreased in the past few years and questions if this is due to steroids. Shern likewise reports a typical verrucous endocarditis in four out of 16 patients not on steroids but no evidence of endocarditis in 11 patients on steroids.

It is possible that the steroids contributed to the development of this unusual infection in the present case. The portal of entry is not clear, however, although her nausea and diarrhea suggest a gastrointestinal route. The immunologic disorder of the upper erythematosus or the immunologic disorder produced by the steroids could have predisposed her to this type of infection. The evidence for bacterial endocarditis includes embolic phenomena-splinter hemorrhages and Osler's nodes—and repeated positive blood cultures and response to antibacterial chemotherapy make the diagnosis secure. This patient also had myocarditis and pericarditis, with heart failure during the course of illness.

A list of references may be obtained by writing The Journal.

Life Span Gains 22 Years in 20th Century

A child born today in the United States can expect to live about 22 years longer than his grandparents, according to a report published in the current issue of *Update*, a publication of the American Medical Association..

That's a gain of 44.5 per cent—or nearly half a lifetime of life span added since 1900. The figures are based on life expectancy data for 1971, recently released by the U. S. Public Health Service. These were compared to similar data for 1900.

"A child born in 1971 can expect to blow out the candles on his (or her) 71st birthday cake," the report says. "Why are people living longer today? One reason is that the average living standard has greatly improved in the past seven decades. Another reason is that more people have learned the value of taking proper care of themselves.

"Also, advances by medical research and medical practice merit a large share of the credit. Since 1900, the U. S. death rate has dropped from 1,719 to 929 per 100,000 persons. That's a drop of 46 per cent.

"At the turn of the century, tuberculosis, gastritis, chronic nephritis and diphtheria were among the top ten leading causes of death. Together, they claimed 458 lives each year for every 100,000 people. Now they are no longer listed as leading killers.

"In their stead, diabetes mellitus, cirrhosis of the liver, arteriosclerosis and bronchitis and related diseases currently appear on the list. But those four killers account for a significantly lower death rate of 63.7 per 100,000.

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Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

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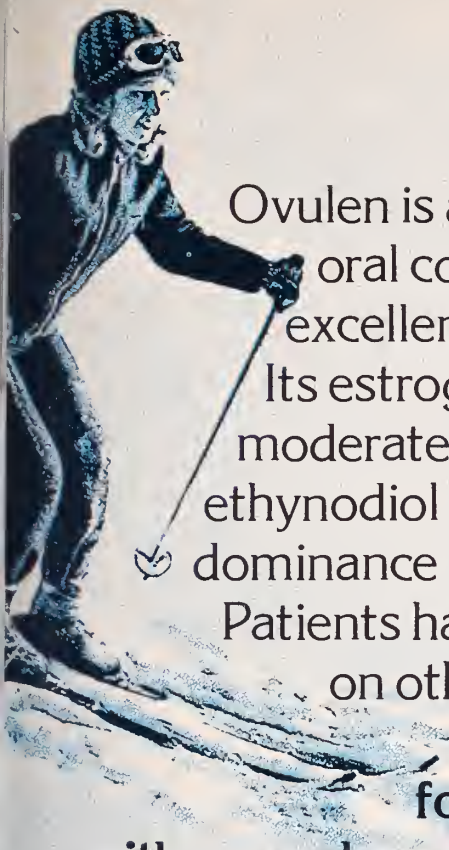

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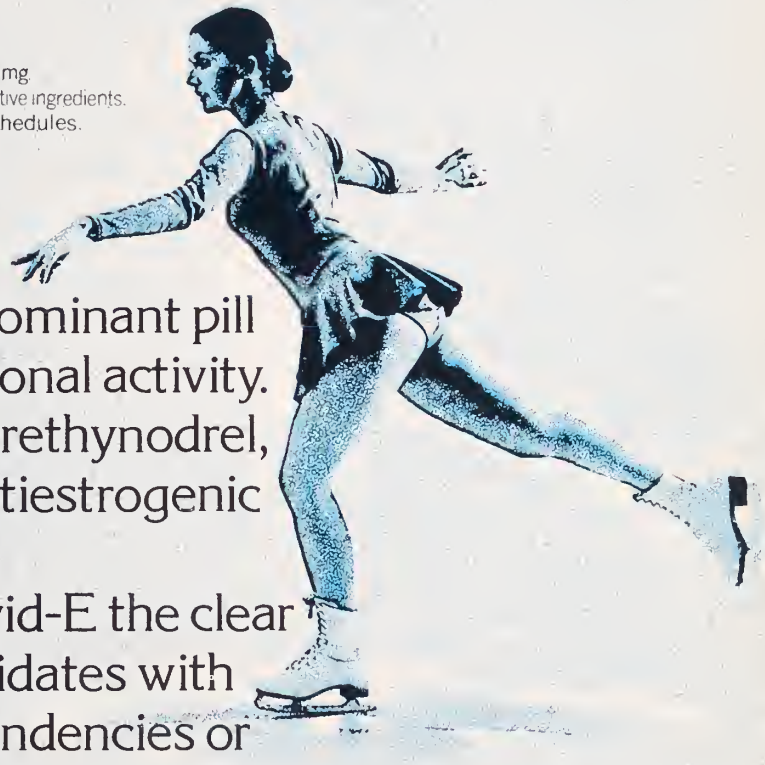

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Special note – Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication – Ovulen and Demulen are indicated for oral contraception.

Contraindications – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis) Should any of these occur or be suspected the drug should be discontinued immediately

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4 4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possibl influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrena hepatic or uterine function awaits further study. A decrease in glucose toleranc has been observed in a significant percentage of patients on oral contracep tives. The mechanism of this decrease is obscure. For this reason, diabetic pa tients should be carefully observed while receiving Ovulen or Demulen therap The age of the patient constitutes no absolute limiting factor, although treatmer with Ovulen or Demulen may mask the onset of the climacteric. The pathologis should be advised of Ovulen or Demulen therapy when relevant specimens ar submitted. Susceptible women may experience an increase in blood pressur following administration of contraceptive steroids

Adverse reactions observed in patients receiving oral contraceptives – A statistically significant association has been demonstrated betwee use of oral contraceptives and the following serious adverse reactions: thrombo phlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relatior ship has been neither confirmed nor refuted for the following serious advers reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving ora contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdom inal cramps and bloating), breakthrough bleeding, spotting, change in menstrua flow, amenorrhea during and after treatment, edema, chloasma or melasma breast changes (tenderness, enlargement and secretion), change in weigh (increase or decrease), changes in cervical erosion and cervical secretions, sup pression of lactation when given immediately post partum, cholestatic jaundice migraine, rash (allergic), rise in blood pressure in susceptible individuals anc mental depression

Although the following adverse reactions have been reported in users o oral contraceptives, an association has been neither confirmed nor refuted anovulation post treatment, premenstrual-like syndrome, changes in libido changes in appetite, cystitis-like syndrome, headache, nervousness, dizzi ness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contra ceptives: hepatic function increased sulfobromophthalein retention and othe tests, coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X thyroid function: increase in PBI and butanol extractable protein bound iodine and decrease in T^3 uptake values, metyrapone test and pregnanediol deter mination

References: 1. Royal College of General Practitioners: Oral Contracep tion and Thrombo-Embolic Disease, J Coll Gen Pract. *13*:267-279 (May) 1967 **2.** Inman, W H. W, and Vessey, M. P Investigation of Deaths from Pulmonary Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968 **3.** Vessey, M P., and Doll, R. Investi gation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med J *2*:651-657 (June 14) 1969 **4.** Sartwell P. E., Masi, A T.; Arthes, F G.; Greene G R, and Smith, H. E Thromboembolism and Oral Contraceptives. An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969

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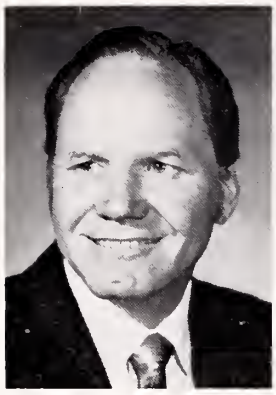

A message from . . .

The President

MUSING ON THE DRUG PROBLEM

THE drug abuse problem is still with us. After speaking to physicians and pharmacists about the problem, I can only conclude that the physicians are contributing to the problem by unnecessary prescriptions and over prescribing in amounts that tend to keep the home medicine cabinet well stocked with "uppers and downers." Authorized refills are also excessive in number.

Most pharmacists are ethical and try to control the filling and refilling of prescriptions. But some are guilty of unauthorized refilling of prescriptions to do the patient a favor or for financial reasons.

The next step is for the adolescent in the family to tap this readily available supply to use or distribute as he sees fit.

Another facet to the problem that should be investigated and controlled is the excessive amount of potent drugs prescribed to patients with mental problems. Drugs to mental patients are dispensed in quantities to last several weeks or longer with little if any supervision of the patient or his medicines.

The Controlled Substance Act of 1970 attempts to control some of the abused drugs, but is almost impossible to enforce. There are only two inspectors in West Virginia to inspect all physicians, hospitals and wholesale and retail druggists, in addition to the investigation of any suspected drug irregularities.

A partial solution to the problem involves restriction of the prescribed supply by the physician and increased vigilance by the pharmacist in filling the prescriptions. The "voluntary outlawing" of certain drugs, such as amphetamines, in certain communities could have an additional effect.

With the drug problem, as in many others, physicians must correct their own deficiencies that contribute to the problem.

Worthy W. McKinney M.D.

W. W. McKINNEY, M. D., *President*

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EDITORIALS

CONSERVATISM AND MEDICINE

It seems that some doctors are embarrassed by the *conservative* label attached to medicine. Advocates of liberal causes, to further their ends, make steady attempts in a tactical effort to attach to conservatism unwholesome connotations such as reactionaryism or obstructionism. The impression given is that it is very fashionable and very intellectual to be liberal in one's views. Vanity alone inclines some doctors to include themselves amongst the intellectuals.

A gauge of the success of this tactical maneuver is the embarrassment noted above. The result, of course, is an unwillingness to be involved in active resistance to liberal schemes by some who might otherwise find themselves in genuine disagreement.

To be consistent with their convictions, most doctors are willing to risk the judgment of being considered unfashionable in their views and to ignore the intimidation of being considered simian in their mentality. They know that conservatism does not imply a total and complete resistance to change, a return to "the good old days and the good old ways." They realize that to be conservative means simply to have the capacity to be selective in culling through that haze of brainstorms which rise like so many heat waves from the fevered brains of professional liberals.

Most conservatives would profess the belief that occasionally an apparently good idea for change does arise. Once perceived, such an idea must be tested in the crucible of conservative doubt and criticism. It must be held in the flame of partisan debate. Its frailties and weaknesses must be exposed. Its end results and its by-products, both good and bad, must be placed in the balance scales. Having passed such an ordeal, an idea may be considered hardy, indeed, and deserving of a cautious trial in practice. It is the role and function of conservative thought and the responsibility of conservative thinkers to resist change, to question proposals for change, and in the process to refine them to the point of extinction or to the extent they may be of benefit to the intended beneficiaries.

The disarray of many of our domestic programs is as much an indictment of conservatives for having failed to mount an effective resistance as it is of liberals for having proposed the failing schemes to start with. Responsible conservatives recognize that change is not only inevitable but even necessary. Recognition of the need for change, however, is simply no reason to accept *any* proposal for change in medicine or in any other field.

Medicine has no need to be apologetic about the number or the extent of changes in the way Medicine has been practiced over any given time period. We can take pride in the fact that the

changes we have supported and put into effect have been good for those we serve, and that the accuracy of warnings and criticisms we have expressed about other changes thrust on us has been borne out in practice.

We have been conscientious and responsible toward our obligation to provide medical care. Our course has been consistently in the direction of progress. We have accomplished this by our willingness to challenge anyone who has leaped up with the cry of, "Forward!" It has been reported that skindivers at night are unable to determine from their own sensory apparatus which way is up and that some, not trusting their instruments, swim down and down, all the while thinking they are heading to the safety of the surface.

We, too, operate in such a murk. Medicine has been and must remain unapologetically, conscientiously and enthusiastically conservative in carrying out its responsibility to assure continuing improvement in health care and to assure that the direction in which we move is, in fact, the direction of progress rather than disaster.

We thank God for our well-intentioned liberal friends with all of their Utopian fantasies, but we beg God to help save us from some of their unholy schemes.

SURVIVAL TIME OF CEREBRAL CELLS FOLLOWING CARDIAC ARREST

In the event of cardiac standstill the physician (if available) is called upon to attempt resuscitation of the heart and restore the circulation. In this connection the important question is how long can the cells of the cerebral cortex withstand the insult of complete interruption of the blood supply without the production of irreversible neurological sequelae or mental deterioration.

It is well known that the cells of the cerebral cortex are quite sensitive to hypoxia and it is, moreover, recognized that the cortex (at least locally) is on the verge of oxygen insufficiency even in its normal state. In fact, the cortex has but a small reserve of dissolved oxygen should the circulation fail completely. There is considerable experimental evidence indicating that following complete cardiac standstill that if the circulation can be restored within three to four minutes the cerebral cells will not be harmed and will return to normal function. If the period of hemic hypoxia exceeds this time limit, the cerebral cells probably will suffer irreparable damage which will, of course, interfere with their normal performance. The damage of the cells will depend upon how long a period the circulation was completely discontinued.

Many degrees of damage are possible; for example, in the newborn cortical blindness or cortical deafness may occur and these conditions may or may not eventually disappear. The most tragic sequela is one which produces a "decerebrate" condition; unfortunately, such an individual may lead a vegetative type of existence the remainder of his life and nothing can be done to restore the normal functioning of his cerebral cells. This may, of course, occur at any age. There are cases on record in which patients lived for 20 years or longer following the time of the initial trauma. Fortunately, the percentage of decebrates is small; a recent report states that from a registry of cardiac arrests of 1,200 cases, there were only eight cases of so-called "decebrates"—even this number, however, is by no means a negligible one.

What can be done to prevent this dreadful sequela following cardiac standstill? The main objective obviously is to restore the circulation to the brain as promptly as possible. There are occasions when nothing can be done because the average individual knows nothing about massage of the intact chest to stimulate the heart, and the patient dies. If, on the other hand, a trained technician or better still, a physician is available the above named procedure should be instituted at once and in a certain number of instances the heart will commence to beat again. Time is of the essence, and if necessary, heroic measures should be used, such as open-chest massage technique.

To reiterate, the most important factor is to restore the circulation to the brain at the earliest possible moment. By doing this the cells of the cerebral cortex will probably not suffer an irreparable damage and will again function normally.

Physicians Hold Down Fees

Doctors generally kept increases in their fees below allowed levels during the first year of wage and price controls, a study published in the current issue of *Update*, a publication of the American Medical Association, reports.

Including outpatient care and inpatient surgical procedures, physicians' fees went up 2.3 per cent. The allowable ceiling for the increases was 2.5 per cent—and only to cover increased costs incurred by physicians.

In contrast, the study reports, the average increase in prices for all other services (except medical care) was 3.6 per cent. The figures are based on the Consumer Price Index for August, 1972, the first anniversary of controls.

GENERAL NEWS

AMA President Honor Guest At 106th Annual Meeting

Dr. Russell B. Roth of Erie, Pennsylvania, President-Elect of the American Medical Association, will be among the honor guests at the 106th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 22-25.

Dr. A. Thomas McCoy of Charleston, Chairman of the Program Committee, said Doctor Roth has accepted an invitation to speak at the first session of the House of Delegates on Wednesday afternoon, August 22.

Doctor Roth will be installed as President of the AMA during the Annual Meeting next June in New York City. He will succeed Dr. Carl Hoffman of Huntington, the current President.

A native of Erie, Doctor Roth was graduated from Yale University and received his M.D. degree in 1939 from Johns Hopkins University School of Medicine. He interned at Johns Hopkins University Hospital and served residencies at St. Mary's Hospital in Pierre, South Dakota, Henry Ford Hospital in Detroit and the Brady Institute in Baltimore.

He served as a Captain in the Medical Corps of the United States Army during World War II and also served as a member of the Surgeon General's Advisory Committee on the United States National Health Survey, 1961-64, and as a member of the Dependents Medical Care Advisory Committee. He is currently a member of the National Advisory Council for HEW Regional Medical Programs and has been a member of the Special Medical Advisory Group for the Veterans Administration.

Doctor Roth's service to the AMA includes participation in several committees and as Chairman of the Key Council on Medical Service. He was named Vice Speaker of the AMA House of Delegates in 1966 and was serving as Speaker when he was named by acclamation as President Elect in 1972.

Russell B. Roth, M. D.

Scientific Program Nearly Completed

Doctor McCoy announced recently that the scientific program for the meeting has been completed with the exception of a session which will be devoted to a "Symposium on Family Practice" at the third and final session on Saturday morning, August 25. Names of the prominent physicians and surgeons who have accepted invitations to appear as guest speakers will be announced in future issues of *The Journal.*

It was previously announced that the first general scientific session on Thursday morning, August 23, will be a "Symposium on New Concepts in the Medical and Surgical Treatment of Coronary Artery Disease." Participants at the second general scientific session on Friday morning will include specialists in the fields of obstetrics and gynecology, surgery, radiology and pediatrics.

Serving with Doctor McCoy on the Program Committee are Drs. William H. Carter of Charleston, C. Richard Daniel of Beckley, Robert G. Janes of Fairmont and Philip M. Sprinkle and J. Hugh Wiley of Morgantown.

Business Meetings Scheduled

The Pre-Convention Meeting of the Council will be held on Wednesday morning, August 22.

The first session of the House of Delegates will be held on Wednesday afternoon and the final session on Saturday afternoon, August 25.

Winter Meeting of the Council In Charleston on Jan. 14

The Winter Meeting of the Council was held at the Holiday Inn No. 1 in Charleston on Sunday, January 14, with the Chairman, Dr. Harry S. Weeks, Jr., of Wheeling, presiding.

Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, announced that the 1973 session of the Legislature had been convened officially on January 10 and following the election of officers on that date recessed until February 14 at which time the regular 60-day session would begin.

It was further reported that no bills were introduced on January 10 but that it was expected a number of major bills of interest would be ready for introduction shortly after the Legislature reconvened in February. Doctor Holroyd announced a decision concerning possible future meetings of the Legislative Committee and Council would be delayed until after the second week of February.

New Member of Publication Committee

Doctor Weeks announced there was a vacancy on the Publication Committee due to the death of Dr. E. L. Gage of Bluefield on October 30, 1972. He said that Doctor Gage had served continuously as a member of the Committee and also as a member of the Editorial Board of *The Journal* since 1955.

The Council unanimously elected Dr. Joe N. Jarrett of Oak Hill to serve as a member of the Publication Committee for the unexpired term which will end on December 31, 1975.

Report of Rehabilitation Committee

Dr. Worthy W. McKinney, the President, reported that Dr. Buford W. McNeer of Hinton, Chairman of the Rehabilitation Committee, had phoned to inform him he would be unable to attend the Council meeting due to illness in the family.

He asked that word be passed along to the Council that members of the Rehabilitation Committee had met in a most successful combined conference with representatives of the West Virginia Division of Vocational Rehabilitation at the Pipestem Resort, December 2-3, 1972. He suggested that the following highlights of his report be presented to Council.

- It was emphasized that the proper function of the Rehabilitation Department's activities is to rehabilitate, and that the number of persons returned to productive endeavor is the only valid measurement of the success of the program.
- Rehabilitation counselors should limit their recommendations for initial medical examinations to those who can in their reasonable and considered opinion be rehabilitated, or release someone else for productive work.
- The "guiding" of patients by counselors to certain physicians is inimical to the program and must be discontinued if it exists.
- The quality of medical examinations rendered by some physicians is not acceptable. Measures necessary to increase the standard of performance will be taken.
- It was pointed out that several members of the Rehabilitation Committee also serve as members of the WVU Liaison Committee and that these physicians should be encouraged to develop a closer liaison with the West Virginia University School of Medicine in an attempt to convince the University that rehabilitation deserves more attention in the classroom as well as in the hospital or clinic.
- A statement of the "second injury law" and its effect on hiring a handicapped or disabled person in industry should be made available to each member of the West Virginia State Medical Association.
- Pulmonary rehabilitation and the immediate pick-up of patients discharged from mental institutions must be recognized as problems needing immediate attention.

New Rehabilitation Medical Director

Doctor McKinney pointed out that Dr. Leslie F. McCoy had recently been appointed Director of Medical Services of the Division of Vocational Rehabilitation and that he should be invited to appear before a future meeting of the Council to discuss the present program and especially proposed changes in re the fee for the initial "general medical examination" rendered by participating physicians.

The Council went on record unanimously as approving the report of Doctor McNeer and further instructed that a letter be sent from the headquarters offices of the West Virginia State Medical Association to each county medical society announcing the availability of Doctor McCoy as a speaker at component medical society meetings throughout the State. Doctor McKinney indicated that Doctor McCoy had stated he would be most happy to present a brief scientific discussion of the latest rehabilitation developments, as well as outlining policies and listen to complaints from physicians in attendance.

Joint Nurses Statement Approved

It was reported that the West Virginia Nurses Association had requested Council endorsement of a revised "Vaginal Examination Statement" which would include properly instructed registered professional nurses performing Papanicolaou smears.

In a letter from Miss Juliann Ritter, Executive Director of the West Virginia Nurses Association, it was pointed out that the roles and responsibilities of registered professional nurses are being expanded to include certain techniques which could be safely included in the overall assessment of an individual.

Miss Ritter pointed out that only properly trained and qualified registered nurses would be given approval to participate in the family planning and prenatal clinics in taking cervical-bacterial smears and cultures and cervical-vaginal Pap smears.

The Council voted to endorse the proposed Joint Statement recommended by the West Virginia Nurses Association.

Election of Honorary Member

The Council unanimously elected Dr. Franklin B. Murphy of Philippi to honorary membership in the State Medical Association. It was reported that Doctor Murphy had retired from active practice after many years of dedicated service to citizens residing in the Tygart's Valley area.

Future Meetings Announced

Doctor Weeks encouraged members to attend the Sixth Annual Mid-Winter Clinical Conference which was scheduled to be held in Charleston on January 20-21. He also indicated that two additional meetings had been scheduled in conjunction with the Conference: (1) a meeting of the WVU Liaison Committee on January 20; and (2) a meeting of the Ad Hoc Committee on Medical Foundations on that same date to discuss the continuation of the Voluntary Office Self-Audit Service experimental project and other important items involving leadership of the State Medical Association.

The meeting was attended by Dr. Harry S. Weeks, Jr., of Wheeling, Chairman; Dr. Worthy W. McKinney of Beckley, President; Dr. A. Thomas McCoy of Charleston, President Elect; Dr. William E. Gilmore of Parkersburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. George R. Callender, Jr., of Charleston, Councilor at Large; Dr. Maynard P. Pride of Morgantown, Member of Executive Committee; Drs. Charles E. Andrews of Morgantown; Thomas P. Long of Man; L. H. Nefflen of Elkins; J. D. H. Wilson of Clarksburg; Joseph B. Reed of Buckhannon; Jack Leckie of Huntington; W. Alva Deardorff and George V. Hamrick of Charleston; Richard G. Starr of Beckley; and John J. Mahood of Bluefield; and Mr. William H. Lively, Executive Secretary; and Mr. Custer B. Holliday, Executive Assistant.

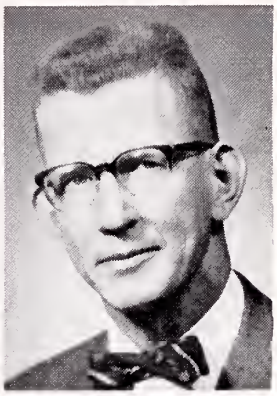
The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Richard E. Flood of Weirton, AMA Delegate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Health Department; Dr. Mildred Mitchell-Bateman of Charleston, Director of the State Mental Health Department; and Mr. James S. Imboden of Columbus, AMA Field Representative.

AAP Spring Session in Boston

Thirty-eight child health care subjects ranging from recent advances in pediatric surgery to adolescent drug dependence will be presented during the American Academy of Pediatrics' annual spring session, scheduled for April 9-12, 1973, in Boston. The four-day meeting at the Sheraton Boston Hotel is expected to draw more than 2,000 persons. The presentations will feature short, practical reports from pediatricians and other child health specialists followed by discussion periods.

Doctor Jarrett Named Member Of Publications Committee

Dr. Joe N. Jarrett of Oak Hill has been named a member of the Publication Committee succeeding the late Dr. E. Lyle Gage of Bluefield, who died on October 30, 1972, after serving as a member since 1955. Doctor Jarrett will serve out the term which ends on December 31, 1975.



Joe N. Jarrett, M. D.

As a member of the Publication Committee, Doctor Jarrett will serve as an Associate Editor of *The West Virginia Medical Journal.*

A native of Morgantown, Doctor Jarrett was graduated from the two-year School of Medicine at West Virginia University and received his M. D. degree in 1939 from the University of Pennsylvania School of Medicine. He interned and served a residency at the University of Pennsylvania Hospital in Philadelphia and was licensed to practice in West Virginia in 1941.

He has been active in the affairs of organized medicine for a number of years and is a Past President of the Fayette County Medical Society. He also served a term as President of the West Virginia Chapter of the American Academy of Family Physicians and was Certified in 1971 as a Diplomate of the American Board of Family Practice.

Doctor Jarrett served for three years with the Medical Corps of the United States Army during World War II and was discharged in 1946 with the rank of Major.

Emergency Physicians Seminar in Florida

A Postgraduate Seminar on Emergency Medicine will be held at the Playboy Plaza Hotel in Miami Beach, Florida, March 21-24, 1973. The seminar will be sponsored by the Florida Chapter of the American College of Emergency Physicians and the Emergency Department Nurses Association. The University of Miami School of Medicine is co-sponsor.

The four-day program is designed to present current pertinent and practical information for those most intimately involved in delivering emergency medical care—the emergency physician, general and family physician, emergency nurse, hospital administrator, etc.

For further information, contact: J. Clifford Findeiss, M. D., Florida Chapter, American College of Emergency Physicians, 11130 S. W. 173rd Terrace, Miami, Florida 33157.

Physical Activity And Aging Conference Scheduled For Charleston In March

The First Appalachian Conference on Physical Activity And Aging will be held in Charleston March 2-4 at the Holiday Inn, Charleston House.

The conference is being sponsored by the Lawrence Frankel Foundation, the Kanawha Medical Society and the Kanawha Valley Heart Association.

Dr. Daniel Brunner

Samuel M. Fox, M. D.

The new event on the state medical calendar will bring together individuals with internationally recognized credentials in the field of geriatrics, cardiovascular medicine, and all related fields of care for the aging. The program will include a demonstration of "Project Preventicare." The program goal, according to the sponsors, is dedicated to cardioprotective health planning and physical fitness revitalization for the elderly and people of all ages.

The conference has been approved for six hours of credit by the American Academy of Family Physicians.

The keynote speaker will be Raymond Harris, M. D., Associate Professor of Albany Medical College and author of "Geriatrics/Cardiovascular Diseases."

Other speakers will include:

- Dr. Hans Kraus, New York University Institute of Physical Medicine and Rehabilitation, internationally known expert on back ailments, and John F. Kennedy's specialist for three years.
- Dr. Ernst Jokl of the University of Kentucky, President of UNESCO Council, for Research in Sports Medicine; regarded as the founder of sports medicine in the United States.
- Professor Kenneth Redden of the University of Virginia Law School, Co-Editor of the "Lawyers Medical Cyclopedia," and former Instructor in Medical Jurisprudence at the University of Virginia.
- Dr. Daniel Brunner, Professor and Head of the Department of Physiological Hygiene, University of Tel Aviv, Israel. In the novel, "Exodus," there is the story of a beleagured kibbutz in a valley and of children being rescued from the hills by the people of the kibbutz who had to cross enemy territory to get to them. Doctor Brunner was the doctor of the story who helped retrieve the children and calm their anxieties.
- Roby Thompson, M. D., Associate Professor of Orthopedics, University of Virginia Hospital.
- Herbert A. deVries, Ph. D., Director, University of Southern California Mobile Laboratory for Physiology of Exercise and Aging Research.
- Samuel M. Fox, III, M. D., Professor of Medicine, George Washington University Medical Center, University Hospital, Washington, D. C.; President, American College of Cardiology.

There will be a registration fee of $35, which will include a cocktail party and evening banquet. A maximum registration of 400 can be accommodated. Reservations will be made in order of their receipt. Registration deadline is February 10. Out-of-town physicians may register through February 20.

For registration blanks and further information, contact: Lawrence Frankel Foundation, Virginia at Brooks Street, Charleston, W. Va. 25301.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected from July 1 through December 31, 1972:

Cabell

Chicklo, James M.	Huntington
Ricard, Jose I.	"
Tweel, Harry K.	"
Valentin, Francisco C.	"

Central W. Va.

Belmonte, Benjamin	Summersville
Bracco, Richard A.	Weston
Mace, Robert M.	Webster Springs

Hancock

Roig, George M.	Weirton
Vista, Reynaldo B.	"

Kanawha

Bangani, Prakash C.	Charleston
De Ocampo, Roberto	Montgomery
Knapp, Mary Frances	St. Albans
Pangilinan, Andres G.	Charlton Heights
Taupradist, Parinya	Charleston
Zeedick, John F. I.	"

Mercer

Mathew, Thomas	Bluefield

Potomac Valley

Tureman, Garnet Roy, Jr.	Moorefield

Raleigh

Castillo, Vicente A., Jr.	Beckley
Honrado, Cordell R.	"
Shacklett, Ernest D., Jr.	"

A list of new Association members who were elected from January 1 through June 30, 1972, was published in the August issue of *The Journal.*

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Enjoying themselves at a recent medical meeting held at the West Virginia University Medical Center in Morgantown were Dr. Richard C. Rashid and Mrs. Rashid of South Charleston.

Over-65 Age Group Shows Increase Despite State Population Drop

The increasing percentage of West Virginians in the retirement age group and their impact on the economy of the state was underscored by the Commission on Aging in its annual progress report to the Governor and State Legislature.

While the total population of the state was dropping by six per cent in the last 10 years, West Virginia's over-65 age group increased by twelve-and-one-half per cent, the Commission noted. The over-65 group now numbers 11.1 per cent of the state population, compared to 9.9 per cent for the nation.

The Commission noted the increasing financial impact of the elderly with more than 200,000 West Virginians over 60 years of age drawing $328 million in Social Security payments during 1972. Studies show that most of the money is spent immediately in the community of the recipient.

Such a financial impact will continue with the 20 per cent increase in Social Security benefits last October. With the increase, benefits distributed in the state this year will be more than $50 million each month.

The financial impact of the older group is further emphasized, the Commission noted, by other programs. Old Age Assistance, the Pharmacy Program for the Aged and Black Lung Benefits brought a total of about $140 million in benefits to the state's elderly last year.

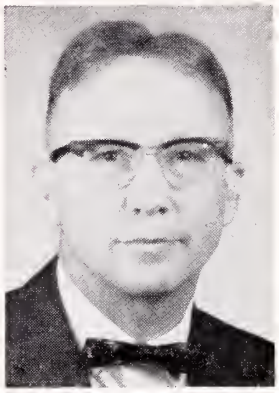
Increasing medical needs, and rising costs, add to the problems of the elderly with 85 per cent of those over 65 having some chronic health problem. Medicare records reveal that about 199,000 West Virginians are covered by the hospital insurance plan and about 193,000 are enrolled in the supplemental medical program.

They received almost $50 million in 1972 toward medical costs.

Dr. Ralph Ryan Honored By Two National Medical Societies

Dr. Ralph W. Ryan, Morgantown eye physician, recently received recognition by two national medical societies.

The American Association of Ophthalmology, at its recent annual convention in Dallas, chose Doctor Ryan to be its President-Elect. He also recently was re-elected to the Board of Directors of the Contact Lens Association of Ophthalmologists for a three-year term.



Ralph W. Ryan, M. D.

Doctor Ryan has held various offices in the American Association of Ophthalmology since being elected to the Board of Trustees in 1962. For the last two years he has served as the President for Socio-Medical Affairs. The AAO has headquarters in Washington.

The Contact Lens Association of Ophthalmologists, with headquarters in New York City, is composed of eye physicians with a particular interest in contact lenses. The organization fosters research in contact lenses and scientific meetings on an international basis.

In 1971, Doctor Ryan was cited for distinguished service by the Pennsylvania Academy of Ophthalmology and Otolaryngology. The award was for his efforts leading to legislation which established the National Eye Institute within the National Institutes of Health in Washington, D. C.

An authority on industrial eye research, Doctor Ryan was instrumental in organizing the Eye Branch of the National Institute of Neurological Diseases and Blindness, and headed the Branch from 1953 to 1955. During this period, he conducted significant research and reported on a successful method for treating uveitis, and on the relationships of specific viruses to what is called "pink eye."

Dr. Ryan is a Past President of the West Virginia Academy of Ophthalmology and Otolaryngology. He received his A. B. Degree from West Virginia University and his M. D. Degree from the University of Michigan. He also holds an M. S. Degree in Ophthalmology from that institution.

MCV Lecture Series March 22-23

The 44th Annual McGuire Lecture Series will be presented by the Medical College of Virginia March 22-23. The postgraduate course this year will be "The Clinical Laboratory in Medical Practice."

College Of Surgeons To Hold New Meeting In New York

Marking a major change in its long-range educational program, the American College of Surgeons will sponsor its first annual four-day Spring meeting in New York on Sunday, April 1, through Wednesday, April 4, at the Americana and Hilton Hotels.

In a sense, the New York meeting will be a four-day workshop devoid of business and social activities. It will provide eight postgraduate courses planned by nearly 150 outstanding surgeons working closely with the Surgical Education and Self-Assessment Program (SESAP) of the College, which now has been subscribed to by more than 12,000 surgeons, including Fellows (members), non-Fellows and residents.

The essential feature of SESAP is a voluntary, self-administered challenge assessment, offering a mechanism whereby participants may accurately measure how well they have kept up with surgical progress, define for themselves alone the areas in which they are deficient, and follow a continuing education program matching their individual needs.

Some of the courses will involve plenary sessions followed by splitting into smaller groups to facilitate participation and discussion. The precise format will be determined by the presiding chairman and SESAP representatives. A surgeon may choose one of four courses during the first two days of the meeting and select another from four other offerings in the second two days.

The nine-hour postgraduate courses will be supplemented by two days of symposia, panels, lectures and motion pictures.

The postgraduate courses will cover:

Pediatric Surgery: J. Alex Haller, Jr., M. D., FACS, Baltimore, chairman and SESAP representative; Thomas V. Santulli, M. D., FACS, New York, co-chairman.

Cancer: Edward J. Beattie, Jr., M. D., FACS, New York, chairman and SESAP representative; Loren J. Humphrey, M. D., FACS, Kansas City, Kansas, co-chairman.

Shock: Arthur E. Baue, M. D., FACS, St. Louis, chairman and SESAP representative; Louis R. M. DelGuercio, M. D., FACS, Livingston, N. J., co-chairman.

Gastrointestinal Surgery: Lloyd M. Nyhus, M. D., FACS, Chicago, chairman; S. Arthur Localio, M. D., FACS, New York, co-chairman, and William S. Blakemore, M. D., FACS, Philadelphia, SESAP representative.

Fluids and Electrolytes: Lloyd D. MacLean, M. D., FACS, Montreal, chairman; William M. Stahl, Jr., M. D., FACS, New York, co-chairman, and Alan P. Thal, M. D., FACS, Kansas City, Kansas, SESAP representative.

Trauma: G. Tom Shires, M. D., FACS, Dallas, chairman; Melvin H. Worth, Jr., M. D., FACS, New York, co-chairman, and Robert J. Freeark, M. D., FACS, Maywood, Ill., SESAP representative.

Peripheral Vascular Disease: Edwin J. Wylie, M. D., FACS, San Francisco, chairman; Arthur B. Voorhees, Jr., M. D., FACS, co-chairman, and Francis E. Rosato, M. D., FACS, Philadelphia, SESAP representative.

Endocrine Surgery: Richard H. Egdahl, M. D., FACS, Boston, chairman; Frank E. Gump, M. D., FACS, New York, co-chairman, and Marion S. DeWeese, M. D., FACS, Columbia, Missouri, SESAP representative.

Panels and Lectures Scheduled

Several panel discussions and symposia are also scheduled, including: Cancer of the Salivary Glands with John J. Conley, M. D., FACS, New York, serving as moderator; Acute Gastrointestinal Hemorrhage, Alexander J. Walt, M. D., FACS, Detroit, moderator; Hand Injuries—The Severed Flexor Tendon, J. Williams Littler, M. D., FACS, New York, moderator; Bypass Surgery for Occlusive Disease of the Coronary Arteries, Frank Cole Spencer, M. D., FACS, New York, moderator; and Respiratory Insuffciency, Thomas F. Nealon, Jr., M. D., FACS, moderator. A Symposium on Cancer will be moderated by Loren J. Humphrey, M. D., FACS, Kansas City, Kansas; and William A. Altemeier, M. D., FACS, Cincinnati, will preside over a symposium on Surgical Infections.

Three lectures will also be given. Hepatitis and the General Surgeon will be the topic of Sheila Sherlock, M. D., of the Royal Free Hospital in London; Granulomatous Disease of the Intestine will be discussed by John Cedric Goligher, ChM, of the Department of Surgery, General Infirmary, Leeds, England; and Hemorrhage and Thrombosis in 1973 is the lecture topic of Edwin W. Salzman, M. D., FACS, Boston.

Fees for postgraduate courses, approved by the American Medical Association for credit as continuing education courses, is $35 for all registrants, manual included. Registration for the meeting is a prerequisite for registering in the postgraduate courses.

Registration for the meeting will be free of charge to Fellows of the College whose dues are paid to date, members of the ACS candidate group, and surgical residents. Non-Fellows, applicants for Fellowship and Fellows whose dues have not been paid, pay $50. Non-Fellows in the Federal Services (full-time) pay $30.

Registered nurses and interns who present proper credentials may register free for the general sessions and exhibits, but are not eligible for the postgraduate courses.

Housing and registration forms are available from the American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

Diabetes Session At Johns Hopkins

A "Symposium On the Management of Diabetes Mellitus and Its Complications" will be held by The Johns Hopkins University School of Medicine Thursday, April 5, at the Thomas B. Turner Auditorium, The Johns Hopkins Medical Institutions, Baltimore, Maryland.

The Symposium is being sponsored in conjunction with the Maryland Diabetes Association.

Speakers will include George F. Cahill, Jr., M. D., Harvard Medical School; James B. Field, M. D., University of Pittsburgh School of Medicine; John Floyd, M. D., University of Michigan Medical Medical School; Max Ellenberg, M. D., Mt. Sinai Medical School; Frederick A. Reichle, M. D., Temple University Health Sciences Center; Addison B. Scoville, Jr., M. D., Vanderbilt University School of Medicine, and members of the Johns Hopkins faculty.

For additional information, write Dean H. Lockwood, M. D., Program Chairman; Maryland Diabetes Association, 407 Reisterstown Road, Baltimore, Maryland 21208.

Cleveland Clinic PG Programs

Three postgraduate programs are being presented by the Cleveland Clinic Educational Foundation in February and March.

The courses and fees are:

"Pharmacology and Clinical Effectiveness of Anti-Inflammatory Drugs," February 21-22, $60; "Sports Medicine (accredited for 15 hours), February 28-March 1, $60, and "New Methods of Treatment in Neurology," March 28-29, $45.

For further information contact the Foundation at 9500 Euclid Avenue, Cleveland, Ohio 44106.

Looking Back 10 Years . . .

Dr. John R. Heller of New York City, left, President and Chief Executive Officer, Memorial Sloan-Kettering Cancer Center, was among the guest speakers at the 11th Annual Scientific Assembly of the West Virginia Chapter, American Academy of General Practice, which was held at the Civic Center in Charleston, May 24-26. Shown with him were, left to right, Dr. James P. Cooney of New York City, Vice President of Medical Affairs of the American Cancer Society; Dr. Robert J. Johnson of Morgantown, President of the West Virginia Cancer Society, and Dr. Richard E. Flood of Weirton, Chairman of the Program Committee.

Doctor Bateman Reappointed NAMH Research Chairman

Dr. Mildred Mitchell Bateman, Director of the West Virginia Department of Mental Health, recently was appointed to a second term as Chairwoman of the Research Committee of the National Association for Mental Health. NAMH is the nation's only voluntary citizens' organization dedicated to fighting mental illness and promoting mental health.

Mildred M. Bateman, M. D.

The work of the committee will be devoted to observation of the research picture in the United States and to social action to close the gaps in mental health and mental illness research by public education and by support of new investigators and new ideas.

Doctor Bateman is a Menninger-trained psychiatrist. She received her Bachelor of Science Degree in 1941 from Johnson C. Smith University in Charlotte, North Carolina, and a Doctor of Medicine degree in 1946 from Woman's Medical College of Pennsylvania (Philadelphia). Doctor Bateman was certified by the American Board of Psychiatry and Neurology in 1957.

Conference On Pregnancy At UK

The University of Kentucky, College of Medicine, will offer a conference on Pregnancy Complications in March. Obstetricians and family physicians will be offered approximately 15 to 20 topics that will be presented by University of Kentucky faculty and guest faculty from other schools.

Pregnancy Complications will be held at the U. K. Medical Center, March 15 to 17. The Program Chairman will be John L. Duhring, M. D. The registration fee will be $75.00. Thirteen hours of AAFP credit has been requested. For further information contact Frank R. Lemon, M. D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Quality Of Life Seminar

The "Second Annual National Congress On the Quality of Life" will be sponsored by the American Medical Association March 7-9 at the Palmer House Hotel in Chicago, Illinois.

The Congress will concern itself with the experiences of the middle years. It will explore the problems and opportunities of this stage of life within a social, educational, and environmental framework.

Applications For Heart Research Grants Accepted Until March 1

Applications requesting heart research grants-in aid are now being accepted by the West Virginia Heart Association, according to an announcement by Robert J. Gardner, M. D., Chairman of the Research Committee.

Each year research scientists and physicians are awarded grants for work in the field of cardiovascular disease. They are not restricted to any particular discipline, although the investigator must be qualified and must have available facilities to pursue his investigation.

Individual requests for grants should not exceed $3,000, although no maximum has been established by the Heart Association's Research Committee. Each applicant will be evaluated by the Committee and awards will be based on merit, needs and available funds.

During the current year, West Virginia Heart Association grants-in-aid have been awarded to 12 scientists and physicians throughout the state. Among the project titles now being investigated are:

Evaluation of Echocardiography in Pediatric Cardiac; Structural Studies of ATP-Myosin Hydroxyamine Complex; Study of Coronary Bypass Grafts and Mammary Implants; An Unsuspected Energy Store for the Heart; Age-associated Systemic Influences on Soluble Collagen; and Effects of Hypoxia on Hypertropic Heart Muscle.

Persons interested in applying should write requesting more information and application blanks from the West Virginia Heart Association, 211 Thirty-Fifth Street, S. E., Charleston, W. Va. 25304. The final deadline for applications for research grants-in-aid is March 1, 1973.

Symposium on 'Pediatric Radiology' Planned in Kentucky

A symposium on "Pediatric Radiology" will be held May 2-4 at the University of Kentucky at Lexington.

The symposium will deal with practical problems in the diagnosis of abdominal, chest, and skeletal disease in childhood.

The guest faculty will include:

Drs. David H. Baker, Babies Hospital, Columbia Presbyterian Medical Center; Lawrence A. Davis, University of Louisville; John Dorst, Johns Hopkins University; Herman Grossman, Duke University; John Gwinn, Childrens Hospital of Los Angeles; Herbert Kaufmann, Childrens Hospital of Philadelphia; M. B. Ozonoff, Newington (Connecticut) Childrens Hospital; Edward Singleton, Texas Childrens Hospital, Houston, and John Tampas, University of Vermont.

For further information contact Frank R. Lemon, M. D., Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Feb. 2-7—Am. Acad. of Orth. Surg., Las Vegas, Nev.
Feb. 8-10—Southeast. Surg. Cong., New Orleans.
Feb. 10-14—Am. Acad. of Allergy, Washington.
Feb. 14-18—Am. Col. of Cardiology, San Francisco.

March 14-15—Spring Meeting, W. Va. Chap., AAP, Morgantown.
March 29-30—AMA Nat. Conf. on Rural Health, Dallas.

April 2-4—ACS (Spring), New York City.
April 2-7—Am. Col. of Rad., San Francisco.
April 6-7—Am. Otol. Soc., St. Louis.
April 6-8—W. Va. Chapter, AAFP, Morgantown.
April 6-8—Am. Soc. Int. Med., Chicago.
April 7-12—Am. Col. of Allergists, Atlanta.
April 8-12—Am. Assn. of Neu. Surg., Los Angeles.
April 8-13—ACP, Chicago.
April 16-18—Am. Assn. for Thoracic Surgery, Dallas.
April 18-21—W. Va. Academy of Ophth. and Otol., White Sulphur Springs.
April 23-28—Am. Acad. of Neurology, Boston.
April 25-27—Maryland Medical, Baltimore.
April 25-27—Am. Surg. Assn., Los Angeles.
April 29-May 2—Am. Soc. for Head and Neck Surgery, Hot Springs, Va.

May 2-5—ACS, W. Va. Chapter, White Sulphur Springs.
May 2-5—Am. Gyn. Soc., Colorado Springs, Colo.
May 4-5—W. Va. Ob. & Gyn. Clinical Workshop, Charleston.
May 5—W. Va. Sec. of Anesth., Morgantown.
May 7-9—Am. Col. of Sports Med., Seattle.
May 7-11—Am. Psych. Assn., Honolulu.
May 7-11—Ohio State Med. Assn., Columbus.
May 13-17—Am. Urol. Assn., New York City.
May 16-20—Am. Ped. Soc., San Francisco.
May 20-23—Nat. TB & RD Assn., New York City.
May 21-24—Am. Col. of Ob. & Gyn., Bal Harbour, Fla.
May 21-24—Am. Thoracic Soc., New York City.
May 28-30—Am. Ophth. Society, Hot Springs, Va.

June 22-23—Am. Diabetes Assn., Chicago.
June 24-27—Am. Assn. of Plastic Surgeons.
June 24-28—AMA, New York City.

Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.
Sept. 18-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 28-Oct. 4—AAFP, Denver.

Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.

Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-13—Am. Heart Assn., Atlantic City.

Nov. 12-15—Sou. Medical Assn., San Antonio.

Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.

vertisement

"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

– George Sarton, from "The History of Medicine Versus the History of Art"

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

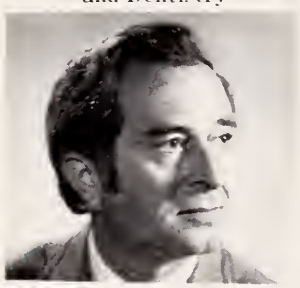
13.8%
Do not believe combination drug products are useful.

Are combination drug produc useful in treatment involvin concomitant use of two or more drugs

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great of money. I wish we agree on a "grandf clause" approach to p rations that have been for a number of year that have an appar satisfactory track rec

For example, I some of the antibiotic binations that were off the market by the performed quite well. thinking particular penicillin - strepton combinations that pa —especially surgica tients—were given i injection. This mad less discomfort for t tient, less deman nurses' time, and opportunities for d errors. To take s preparation off the m doesn't seem to be medicine, unless actu age showed a great d harm from the inje (rather than the p use) of the combinati

The point that sho emphasized is that are both rational and tional combinations. real question is, who s determine which is w Obviously, the FDA play a major role in ing this determinatio fact, I don't think i avoid taking the ulti responsibility, but it s enlist the help of o physicians and exper assessing the evidenc in making the ultimat cision.

Maker of Medicine

V. Clarke Wescoe, M.D.
President
Winthrop Laboratories

If two medications are ed effectively to treat a tain condition, and it is own that they are comtible, it clearly is useful d convenient to provide m in one dosage form. would make no sense, in t it would be pedantic, insist they always be escribed separately. To oid the appearance of dantry, the "expert" dees the combination beuse it is a fixed dosage m. When the "expert" okes the concept of fixed sage form he obscures fact that single-ingreent pharmaceutical prepations are also fixed sage forms. By a singular nantic exercise he imes a pejorative meaning the term "fixed dose" ly when he uses it with spect to combinations. hat is ignored is the simfact that only in the rest of circumstances es any physician attempt titrate an exact therautic response in his pant. It is quite possible at some aches and pains ll respond to 500 mg. of pirin yet that fact does t militate against the *usl* dose being 650 mg.

The other semantic ploy en called into play is to scribe a combination oduct as rational or irranal.

Take antibiotic mixtures, e source of much of the ticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

MINOCIN® made the difference in just eight days.*

Clinical Data:
Patient: 47-year-old male.
Diagnosis: Severe pyoderma, left hand.
Culture: *Staphylococcus aureus, coagulase* positive and sensitive to MINOCIN.
Temperature: 102° F
Therapy: MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.
Concomitant therapy: None.†

Semisynthetic
MINOCIN®
MINOCYCLINE HCl
Capsules, 100 mg: 2 *stat*, 1 q 12 h.

Indications: For the treatment of susceptible infections; *e.g., E. coli, D. pneumoniae.* For full list of approved indications consult labeling.
Contraindications: Hypersensitivity to any tetracycline.
Warnings: The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. *Pregnancy:* In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. *Newborns, infants and children:* All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (*e.g.*, renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *CNS:* (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

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WVU Medical Center
–News–

Dr. Phillip B. Mathias of Morgantown recently was elected President of the WVU School of Medicine Alumni Association. Other new officers include Drs. Pat A. Tuckwiller of Charleston, President-Elect; Clark K. Sleeth of Morgantown, Secretary-Treasurer; and Executive Council members, J. Hugh Wiley, Morgantown, Chairman; William N. Walker, Jr., Bridgeport; Jimmy L. Mangus, Charleston, and Dr. Alfred D. Ghaphery of Wheeling.

Anatomists Name Doctor Jones

Doctor David S. Jones, Professor of Anatomy and Surgery at the WVU School of Medicine, was named President-Elect of the Southern Society of Anatomists at its recent meeting in Little Rock, Arkansas. Doctor Jones and Dr. Donald H. Enlow, Chairman of WVU's Department of Anatomy, also presented scientific papers during the sessions.

Doctor Mathias

Doctor Jones is a nationally-known anatomist. He was the founder of the Midwestern Society of Anatomists and he is a Past-President of the Cajal Club, an organization for neuroanatomists.

HEW Appoints Doctor Todd

The Medical Center's Dr. Jean E. Todd is one of five persons named recently by the Department of Health, Education and Welfare to the Coal Mine Health Research Advisory Council. She will serve until 1976. The Council meets three times a year and makes recommendations to HEW regarding coal mine health research. Doctor Todd, formerly a senior consultant at the National Cancer Institute, has been at WVU since 1971 as Professor of Pathology and Surgery and Director of Surgical Pathology. A native of Breat Britain, where she graduated from Cambridge University, she received her medical degree with honors at Canada's McGill University in Montreal.

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

Doctor Chung Speaks In Singapore

Dr. Edward K. Chung, Medical Center cardiologist, was one of eight official delegates from the United States to the V Asian-Pacific Congress of Cardiology which was held recently in Singapore. Doctor Chung spoke on "Rationale of Drug Therapy" at the Cardiac Arrhythmias Symposium and was chairman of a free communication session on "Digitalis." At the Plenary Session on Controversies in Cardiology his topic was "The Prophylactic Use of Antiarrhythmic Drugs in Acute Myocardial Infarction."

Doctor Chung also conducted courses for one day during the American College of Cardiology Department of Continuing Education program held recently at Rancho Santa Fe, California.

Among those present at a recent gathering of WVU School of Medicine alumni in Morgantown were (left photo) Drs. Robert Greco ('46), of Morgantown, and Terrell Coffield ('42), New Martinsville. On the right are Dr. Pat A. Tuckwiller ('26), of Charleston, President-Elect of the School of Medicine Alumni Association, and Mrs. Tuckwiller.

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The Month in Washington

• From the Washington Office of the American Medical Association.

NEW faces will be leading the nation's major governmental health programs in President Nixon's second term in office. At the helm of the Department of Health, Education and Welfare will be a new kind of Secretary, a man with a reputation as a budget slasher with a zeal for protecting the taxpayers' dollar.

Caspar Weinberger will be the first HEW secretary schooled in the money world of fiscal prudence. Nicknamed "Cap the Knife," the appointment of Weinberger to run the government's social welfare, health and educational programs perhaps marks the President's most daring cabinet decision.

Selection of the 55-year-old California lawyer seems to be proof of the President's intention to reverse the tide of heavier federal welfare spending, to channel more money and responsibilities to states and localities, and to steer away from the European welfare state concept.

Weinberger will be moving over to HEW from the post of Director of the White House Office of Budget and Management, a cabinet post but one where Weinberger was able to function in the comparative anonymity he has preferred to date. At HEW he will be thrust into the limelight and in short time will become one of the best known public figures in the nation.

Despite its reputation as a wrecker of reputations, the HEW Department secretaryship has served most of its occupants well. Outgoing Secretary Elliot Richardson was elevated to the more powerful and prestigious post of Defense Secretary. Abraham Ribicoff, who despaired of presiding over the "can of worms" at HEW, found his tenure there no handicap in his race for the Senate.

Ribicoff will be one of the senators present at the Senate Finance Committee confirmation hearing in January on Weinberger's nomination. The confrontation between Ribicoff and Weinberger promises to be an interesting exchange as Weinberger outlines his views on his new position and Ribicoff contributes his advice.

Few fireworks are expected at the confirmation hearing. No committee on Capitol Hill is more conscious of the waste and duplication at HEW than Senate Finance which has a membership considerably more conservative than the Senate as a whole.

Weinberger undoubtedly will give a good picture of his general views and philosophies during his appearance. If he follows tradition, a more detailed explication will be made at a news conference after he is confirmed and sworn in as HEW Secretary.

No Stranger To HEW

Weinberger is no stranger to the operations of HEW. At the Budget Office he became well acquainted with the finances of HEW and indeed in tandem with the White House exerted extraordinary fiscal powers over federal health programs.

Weinberger's appointment may end a chafing dichotomy between the White House staff and the White House OMB on the one hand and HEW on the other. As a loyal Administration servant, Richardson was willing to put up with the situation while it lasted but it is doubtful he would have remained compliant much longer.

There's little question that Weinberger is going to propose HEW cuts that will enrage some congressmen, but on the whole the expectation here is that he won't be easily categorized except perhaps as a pragmatist.

He has noted for example, that more than 71 per cent of federal expenditures are for things over which the Administration has no control—such items as interest on the national debt, Medicare, and veterans compensation.

Other New Faces

John G. Veneman, the number two man at HEW, has also announced his resignation, presumably with an eye to running for Lieutenant Governor of California.

Veneman was a frequent spokesman for HEW before the Congress before he became Under Secretary of Health, Education and Welfare in 1969 at the request of then—HEW Secretary Robert H. Finch.

Frank C. Carlucci, the former Director of the Office of Economic Opportunity who now is Deputy Budget Director is in line to replace Veneman. Carlucci was number two man in the Office of Management and Budget to Caspar Weinberger.

Carlucci's place in the Office of Management and Budget will be taken by Fred Malek, the Nixon Administration troubleshooter who now heads recruiting efforts in the reshuffle taking place before the President's second term.

Also departing from the command line-up at HEW are Assistant Secretary for Health and Scientific Affairs, Merlin DuVal, M. D., and Vernon Wilson, M. D., chief of Health Services and Mental Health Administration.

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Reconstructive Surgery
Head & Neck Surgery
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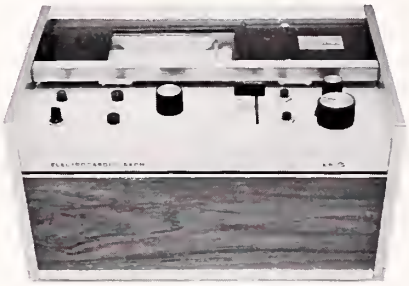

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Obituaries

ROBERT O. CANADA, JR., M. D.

Dr. Robert O. Canada, Jr., on the staff of The Greenbrier Clinic at the Greenbrier Hotel, White Sulphur Springs, died December 5 in Tokyo, Japan after suffering a heart attack while on vacation there. He was 59. A retired Rear Admiral in the U. S. Navy, Doctor Canada was former Commanding Officer of the National Naval Medical Center in Bethesda.

He had been in command of the Center from 1967 until retirement in 1969, when he joined The Greenbrier Clinic. Earlier he had been Commanding Officer of the Bethesda Naval Hospital and Deputy Surgeon General of the Navy.

Born in Grottoes, Virginia, he was educated at the University of Virginia and received his M. D. degree from the Medical College of Virginia. He entered the Navy Medical Corps in 1938.

A pioneer in the antibiotic treatment of tuberculosis, he had specialized in pulmonary diseases. He was certified by the American Board of Internal Medicine and the American College of Chest Physicians, was a Fellow of the American College of Physicians and a member of the Clinical Climatological Medical Society and the American Thoracic Society. He also was a member of the Greenbrier County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Survivors include the widow; a son, Robert O. Canada, III, of Utica, New York; his mother, Mrs. Robert O. Canada, Sr., of Grottoes; and a sister, Mrs. John O'Donnell, of Orlando, Florida.

* * * *

EDWIN J. HUMPHREY, JR., M. D.

Dr. Edwin J. Humphrey, Jr., Huntington gynecologist and obstetrician, died on December 24, 1972 at his home after an illness of several months. He was 64.

Doctor Humphrey was a past president of the medical staff at St. Mary's Hospital in Huntington, having served in that capacity in 1964. He also was a member of the staff at Cabell-Huntington Hospital.

Born at Belleville (Wood County), West Virginia, Doctor Humphrey received his M. D. degree from the Medical College of Virginia. He served his internship at the Chesapeake & Ohio Hospital in Huntington.

He was a member of the Cabell County Medical Society and a past Secretary of the Society.

Doctor Humphrey also was a member of the West Virginia State Medical Association, the American Medical Association, the Southern Medical Association, the Southern Obstetrical Gynecologic Society, and the American College of Obstetricians and Gynecologists. He also was a member of the

(Continued on page xx)

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American College of Surgery, the American Board of Obstetricians and Gynecologists, and the American College of Obstetric and Gynecologic Science.

Survivors include his widow; two daughters, Mrs. Paul C. Pancake, Jr. of Huntington and Mrs. Jane H. Pond of Suffolk, Virginia; a son, Dr. Edwin J. Humphrey, III of Huntington; two sisters, Mrs. J. M. Bosa of Belleville and Mrs. Brady Buckley of Springfield, Massachusetts; a brother, Errett Humphrey of Parkersburg, and eight grandchildren and two great-grandchildren.

* * * *

WILLIAM T. OWENS, M. D.

Dr. William T. Owens of Clarksburg died December 8 in a local nursing home. He was 87.

A native of Weston, Doctor Owens started his practice in Mt. Clare in 1908 and went to Clarksburg in 1915. He continued his practice there until his retirement in 1949.

He received his premedical education from West Virginia University and his medical degree from the College of Surgeons at Baltimore, Maryland.

Doctor Owens was a member of the Harrison County Medical Society, the First Baptist Church of Clarksburg, and Hermon Lodge No. 6, AF and AM. He was the last charter member of Alpha Theta Chapter of Pi Kappa with over 60 years of membership. He was a veteran of World War I. During World War II he was on the Induction Board.

Doctor Owens is survived by the widow.

* * * *

HOWARD G. WEILER, M. D.

Dr. Howard G. Weiler, a prominent orthopedic surgeon in Wheeling for nearly 40 years, died in a Wheeling hospital on December 26, 1972. He was 69.

Doctor Weiler received his B. S. degree in Medical Science at West Virginia University in 1925 and his M. D. degree from Jefferson Medical College in Philadelphia in 1927. He completed orthopedic specialty training at Harvard Medical School and Massachusetts General Hospital in Boston in 1932. In 1933, he began his practice in his office located in the Central Union Building, Wheeling.

Doctor Weiler served in the U. S. Army Medical Corps during World War II. He was a member of the Ohio County Medical Society and was President of the Society in 1948. He was a member of the West Virginia State Medical Association, the American Medical Association, the American Academy of Orthopedic Surgeons, the International College of Surgeons, the Southern Medical Association, and the Tri-State and Interstate Orthopedic Societies.

He also was a member of American Legion Post 1 of Wheeling, Huntington Lodge 53, AF & AM; a 32nd Degree Scottish Rite Mason, the Osiris Temple of the Shrine, and Wheeling Country Club. He

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was a past State President and National Trustee for the Sons of the American Revolution in the State of West Virginia.

Dr. Weiler was born in Marietta, Ohio. He was a member of Vance Memorial United Presbyterian Church.

He is survived by his widow; a daughter, Mrs. John E. Lilly, Jr. of Birmingham, Michigan; two sons, Dr. Robert R. Weiler and H. Bruce Weiler, both of Wheeling; a brother, Laurence J. Weiler of Baytown, Texas; and six grandchildren.

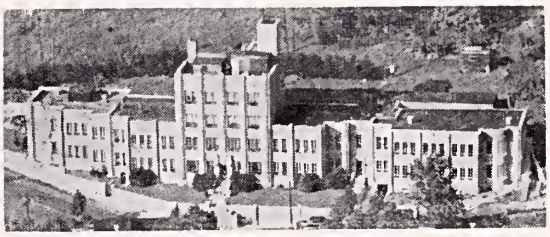
* * * *

THOMAS S. SEXTON, M. D.

Dr. Thomas S. Sexton, Senior Vice President and a Director of Massachusetts Mutual Life Insurance Company, died in his office on January 9 from a heart attack. He was 59.

A native of Sistersville, Doctor Sexton maintained close relations with West Virginia and was a speaker at the 1969 Annual Meeting of the West Virginia State Medical Association at The Greenbrier.

Doctor Sexton was a graduate of West Virginia University, and received his medical degree and a Certificate of Honor from the University of Maryland College of Physicians and Surgeons. He held a fellowship in internal medicine at the Mayo Foundation for Medical Education and Research in 1941 and also between 1945 and 1947. He joined the insurance company's medical staff in 1947.



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Book Reviews

CURRENT PEDIATRIC DIAGNOSIS AND TREATMENT—By C. Henry Kempe, Henry K. Silver and Donough O'Brien. Second Edition. Lange Medical Publications, Los Altos, California. 1972. Price $12.00.

This is a distillation of the art and science of pediatrics, as it was perceived at the beginning of 1972 by the senior authors and their associates, all of whom, with one exception, are listed as present, or former, members of the faculty of the University of Colorado Medical Center. Information is presented clearly, concisely and positively, with no discussion of controversies or different points of view. The experienced pediatricians will not agree with all of the statements made, and will wish for more background for some of them, but he can recognize that the authors are able to speak with authority.

The editors and publishers have created a book from which information is very readily obtained. The two column layout makes for rapid reading. Subjects are clearly separated by spaces and their titles are given in large type, so that it is possible to scan an entire chapter in a few minutes. Numerous figures and tables make such essential data readily visible. It would have been helpful if these had been referred to by page, as well as chapter and sequence number. For those who would like to pursue any subject, there are references at the end of each section. This is much more convenient than a long bibliography at the end of a chapter.

The arrangement of the subjects covered is quite natural and logical. At the beginning is a very complete outline of the history and physical examination, which can be read with profit by even the most experienced. Growth and Development, the Newborn and Premature, the Adolescent, Nutrition and Immunizations each has a chapter. New to this edition is a discussion of Ambulatory Pediatrics. Following these general topics, there are chapters devoted to the various systems of the body, and to diseases of common etiologies. Detailed considerations of diagnosis and treatment are concentrated in the last five chapters.

This book is much appreciated by one who has spent many years in pediatrics, with too little time for reading and postgraduate courses. Conditions, especially critical ones, are presented in the way one looks at a patient. For example, the section on head injuries is well worth a few minutes, before going to the emergency room. The discussion of each disease begins with the essentials of diagnosis, in a few lines, enough to tell whether one should look further, either at the subject or the patient. Pediatrics is very thoroughly covered, even the rare, once in a life-time disordered being described in a brief paragraph or a table of differential diagnoses.

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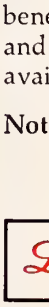

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Vol. 69 No. 3

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Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictabilit More Important Than P

Although the questio price has been greatly aggerated, it is true t patients can on occas save money on gene drugs. But you are not ing to dare attempt to s money if it jeopardizes patient's health. Let's turn to the example t has become very promin in recent years, that of cardiac glycosides. Tl are probably the most tc drugs we use with resp to the small difference tween a maximally effec dose and a toxic dose. Wl you are dealing with dr of this type, the first c cern must be clinical p dictability. At the risk variations in bioavaila ity, it would be sheer fo to try to save the pati what might amount maybe $10 or $20 a y The physician cannot m age his patient unless h sure that the drug he prescribing has the sa positive effect each t the prescription is renew This is especially sign cant when the patient ta the product, not for mon but for the rest of his lif

Maker of Medicine

C. J. Cavallito, Ph.D.
xecutive Vice President
Ayerst Laboratories

Although equivalence of ferent preparations of a ig *substance* may be de- ed by certain physical, mical or biological char- eristics, identity is not ays assured even though se characteristics may described in compendia h as the USP, NF or de- ed by other specific rce standards. More- r, even with equivalent ig substances, similar armaceutical *products* be produced by differ- t manufacturers such t these products are bio- ically or therapeutically quivalent.

A Growing Awareness of Potential for Nonequivalence

As experience increases th drug substances de- ed from different sources d under different condi- ns, it should be possible establish specifications in ficient detail to minimize potential for their non- uivalence. However, ere is general agreement at product therapeutic uivalence would still not assured even if one could minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequivalent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalance have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these individuals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

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Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reaction: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. *Skin:* maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). *Renal toxicity:* rise in BUN, dose-related (see "Warnings"). *Hypersensitivity reactions:* urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. *Blood:* hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. *CNS:* (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

***Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.**
†Case Report, Clinical Investigation Department, Lederle Laboratories.

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The West Virginia Medical Journal

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Foreign Bodies In The Tracheobronchial Tree:

(Report of a Foreign Body Removed Successfully by Endoscopy Six Years Following Aspiration)

Raymond C. Bonnabeau, Jr., M. D., and John R. Bowers, M. D.

Approximately two per cent of all endoscopy is performed for the removal of foreign bodies in the tracheobronchial tree and esophagus—the majority of these patients being less than five years of age.

This paper reports the successful endoscopic removal of a foreign body (upholstery tack) which had been retained in the tracheobronchial tree of a young teenage male for a period of six years.

The Authors

- **Raymond C. Bonnabeau, Jr., M. D., Assistant Professor of Surgery; and John R. Bowers, M. D., Assistant Professor of Anesthesiology; both at the West Virginia University School of Medicine, Morgantown.**

Clinical Report

R. T., a 15-year-old boy, was admitted to the West Virginia University Medical Center on March 18, 1972, with a two-year history of progressive cough. Chest x-ray at that time revealed an upholstery tack in the right lower lobe bronchus (Figure 1a, b). Historically, the patient had been helping his family re-upholster a chair six years prior to admission when he coughed and accidentally aspirated one of the tacks he had been holding in his mouth. He did not tell anybody and remained essentially asymptomatic over a four-year period, at which time the cough developed for which he eventually sought medical aid.

The following day (March 19, 1972), utilizing a combination of local (four per cent Xylocaine) and intravenous, Inapsine (Droperidol®) and Sublimaze (Fentanyl®) anesthesia, bronchoscopy was carried out. The right lower lobe bronchus was found to be filled with a moderate amount of purulent material. Following its removal, the point of the retained upholstery tack was seen protruding from a large mass of chronic granulation tissue (Figure 2). The surrounding bronchial wall revealed evidence of chronic and acute inflammation. The tack (Figure 3) was then removed after the point had been grasped under fluoroscopic control by means of a cross action forceps (Figure 4J). A bronchogram obtained several days postoperatively (Figure 5) revealed cylindrical bronchiectasis of the right lower lobe. Because sputum cultures had grown coagulase positive staphylococcus aucrus, the patient was discharged on Prostaphlin and followed on an out-patient basis.

Comment

Endoscopy to retrieve a foreign body in each case will present individual problems both in terms of the choice of the anesthetic agent used and in the mechanics of the actual removal. These, in turn, depend not only upon the age of the patient, but also upon the location, the position, the anatomy of the foreign body itself and (as in the case presented) the length of time that the object has been "*in situ*".

In the pediatric age range general anesthesia (halothane or penthrane) has been most commonly employed to facilitate foreign body removal and to meet the criteria as stated. In older patients, however, topical four per cent Xylocaine administered by the endoscopist together with some form of intravenous anesthestic agent

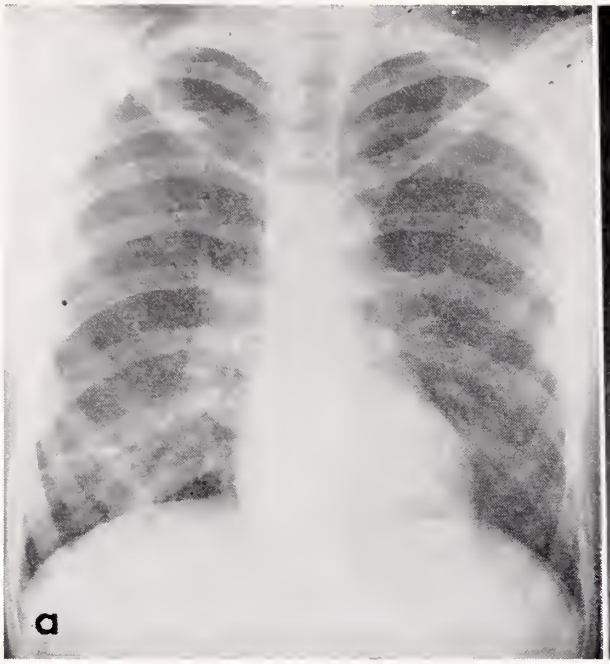

Figure 1a

Figure 1b

has been commonly relied upon. Thus, successful removal of a foreign body depends largely upon the anesthesiologist and endoscopist cooperating maximally as a team.

Because the foreign body in the case presented had been "*in situ*" for six years, it was felt that removal under direct vision might be impossible and that manipulation under fluoroscopic control would, as a result, become necessary. As a result of all these factors, the combination of maximal patient sedation was required. To achieve this end the technique of Neuroleptanalgesia was chosen. This was carried out initially by combining two cc. of Innovar® with four tenths mg. of Atropine sulfate intramuscularly as the preoperative medication. Subsequently, four per cent Xylocaine was administered as a topical anesthetic to the oropharyngeal, laryngeal and tracheal areas. Inapsine was next given intravenously to sedate the patient. Then after a 10 minute wait and just prior to insertion of the bronchoscope, one tenth mg. of Sublimaze was given intravenously for analgesia. A total dose of three tenths mg. of the latter was given in

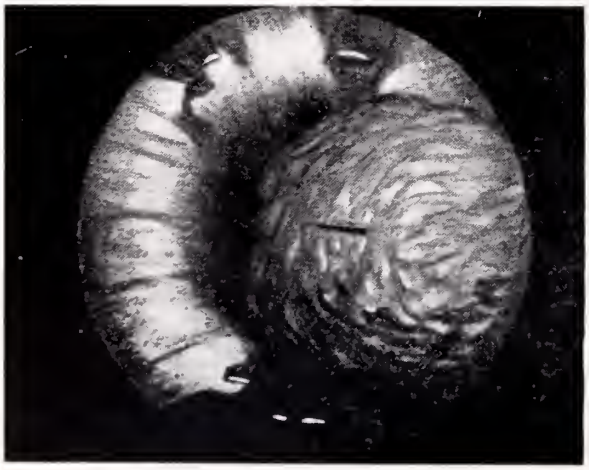

Figure 2

Figure 3

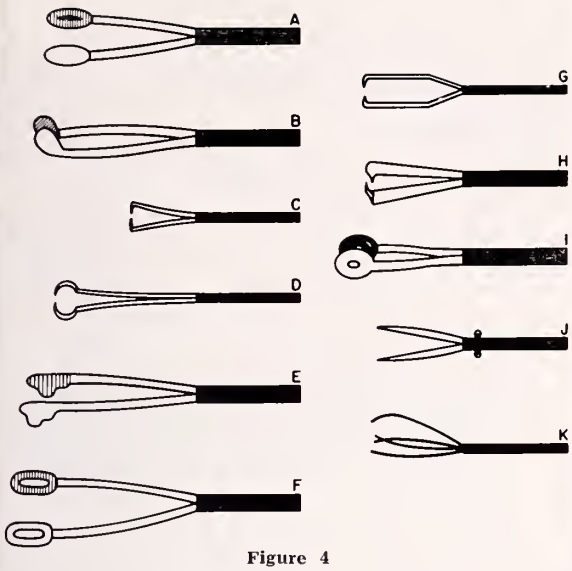

Figure 4

five one-hundredths mg. increments throughout the procedure. Although both Inapsine and Sublimaze are present in Innovar® (50:1 ratio, Inapsine to Sublimaze) separate usage of these medications allows them to be individually titrated to achieve both the dissociative and sedative effects of Inapsine together with the analgesic effect of Sublimaze without the excessive postoperative sedation that may attend their use in the fixed Innovar® ratio. Thus, the patient had the necessary sedation during the endoscopic procedure, but still was able to cooperate fully. Patient cooperation was of special significance in this case, since fluoroscopic manipulation was necessary. The mechanics of removal was facilitated also by the use of cross action type forceps which allows maximal tip grasping power (Figure 4J).

Prior to hospital discharge, bronchography should be carried out in all patients who have

Figure 5

had foreign bodies retained in the tracheobronchial tree for prolonged periods of time, since bronchiectasis (requiring eventual pulmonary resection) can result. In the case presented, bronchography revealed cylindrical bronchiectasis of the lower lobe of the right lung, which was considered reversible.

Conclusion

Removal of a foreign body (upholstery tack) which had been present for six years in the lower lobe bronchus of the right lung of a 15-year-old boy by means of bronchoscopy utilizing neuroleptanalgesia is reported.

The need of maximum cooperation between anesthesiologist and the endoscopist in these cases is stressed.

Treatment of Hypercalcemia with Furosemide And Corticosteroids*

Derrick L. Latos, M. D., and Albert M. Valentine, M. D.

HYPERCALCEMIA may require immediate attention to prevent or reverse the serious complications which may rapidly ensue. Effective treatment of this entity can be extremely difficult if not impossible.

Suki et al first reported[1] successful treatment of hypercalcemic patients with furosemide-induced diuresis. This potential role of furosemide was suggested by the fact that furosemide causes increased urinary calcium excretion. Found to be relatively safe and rapid, this mode of treatment has proven to be quite effective in therapy of acute hypercalcemia. Complications due to the use of furosemide have been virtually limited to those of fluid and electrolyte aberrations, but even these are avoided with careful monitoring and replacement.[2] Reversible ototoxicity has been reported with the use of extremely high doses in patients with severe renal impairment.[3]

The purpose of this paper is to provide discussion of the treatment of hypercalcemia with furosemide and corticosteroids.

Case History

A 57-year-old black woman was admitted to the hospital because of increasing weakness and difficulty swallowing and speaking over the seven to ten days preceding admittance. She had had multiple myeloma since 1968. Boeck's sarcoid was diagnosed in 1963 with apparent remission since 1968. In addition, she had long-standing hypertensive cardiovascular disease with recent onset of atrial fibrillation. She had received a course of Melphalan, Procarbazine, and Prednisone just six weeks previously.

Physical examination revealed an extremely lethargic, late middle-aged black woman. Measurement of vital signs revealed blood pressure 180/130; respirations 14/minute; pulse irregularly irregular approximately 90/minute. Alopecia secondary to radiotherapy was present. A right parietal soft tissue mass three cm. in diameter was noted. Though skin turgor seemed normal, intraocular tension appeared decreased. Generalized abdominal tenderness was noted. Neurological examination was unremarkable except for hyperreflexia in the upper extremities and hyporeflexia in the lower extremities.

Significant laboratory data included: hematocrit 35, hemoglobin 10.4, total protein 11.5 Gm. per cent, serum calcium 16.5 mg. per cent, serum phosphorous 4.9 mg. per cent, BUN 32 mg. per cent, uric acid 15.5 mg. per cent, creatinine 2.3 mg. per cent, Cl. 92 mEq/L, CO_2 content 34 mEq/L, K 2.8 mEq/L, Na 142 mEq/L. Serum protein electrophoresis was consistent with the diagnosis of multiple myeloma. Electrocardiogram revealed atrial fibrillation and short QT interval. A chest x-ray was unremarkable except for the presence of a large extrapleural mass, suggesting metastatic disease.

Method of Treatment

After serum K was brought to normal by KCl supplementation, treatment was begun with methylprednisolone 80 mg. intravenously every four hours and furosemide 80 mg. intravenously every two hours. Hourly urine output was monitored and appropriate intravenous replacement made. After 20 hours of this regimen, serum calcium remained elevated at 15.5 mg. per cent (Figure 1). Furosemide infusion was increased to 80 mg. hourly for five hours, resulting in reduction of serum calcium to 14.2 mg. per cent. Following 14 hours of diuretic administration every other hour again, serum calcium was 12.3 mg. per cent. Furosemide 80 mg. was continued at six-hour intervals for 24 hours and discontinued; at this time, serum calcium was 9.9 mg. per cent. Methylprednisolone was withdrawn

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*This paper was submitted to the Editorial Board while Doctor Latos was a senior medical student at the West Virginia University School of Medicine.

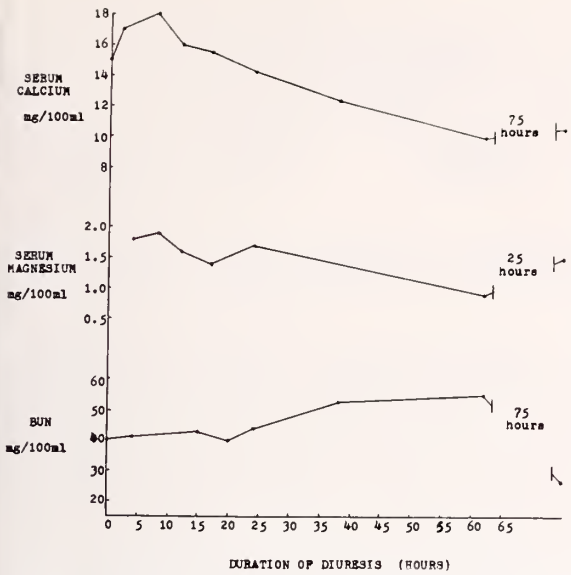

Figure 1. Relation between serum calcium, serum magnesium and BUN during furosemide-induced diuresis. Intravenous Methylprednisolone 80 mg. was administered every four hours.

gradually beginning the day after cessation of furosemide.

Serum magnesium levels were periodically determined and maintained by intramuscular injection of 50 per cent $MgSO_4$. Total intravenous replacement volume for any given hour was made equal to the urine volume of the previous hour. Urine Na and K analysis performed on the first hour sample after furosemide was begun yielded excretion rates of 118 mEq/L and 13.3 mEq/L, respectively. Simultaneous infusion, using separate IV catheters, of 1000 cc. normal saline + 20 mEq KCl and 1000 cc. 5 per cent dextrose in water at a flow rate of 4:1 resulted in a solution whose electrolyte concentration approximated that of the urine. Frequent determinations of serum electrolytes and BUN were made, as well as repeat analysis of urine Na and K. The total furosemide dosage administered was 2080 mg., 1120 mg. of which was given in a single 24-hour period.

During the course of therapy, the patient's mental status progressively improved and she began taking oral nourishment voluntarily at the end of this period. Her continued improvement was manifested by increased strength and complete clearing of mental status. Three weeks after acute diuretic treatment, she remained alert and was ambulatory. Serum calcium had remained stable, at that time being 9.4 mg. per cent. In the meantime, she was begun on a repeat course of Melphalan, Procarbazine, and Prednisone, and a sodium fluoride regimen for multiple myeloma.

Discussion

As with several cases described by Suki et al,[1] this patient's hypercalcemia responded quite well to massive diuresis with furosemide. The most important factor in using this method is diligent monitoring and replacement of urinary water and electrolyte losses, especially those of Na, K, and Mg. While urine output was less than 50 cc./hour before treatment, it ranged between 300-500 cc./hour (average 350 cc./hour) during the entire diuresis. This represents at least a seven-fold increase in urine flow compared with the ten-fold increase described by Suki et al.[1] At the onset of treatment, urine excretion of Na and K was 118 mEq/L and 13.3 mEq/L, respectively. Twenty hours later, after 38.5 per cent of the total dose of furosemide had been administered, excretion of these ions had changed to 136 mEq/L and 17.5 mEq/L for Na and K, respectively. As can be seen from Table 1, a 4:1 flow rate of the solutions described above will replace 123 mEq/L of Na and 16 mEq/L of K. Na and K excretion rates are essentially within this replacement range. That adequate electrolyte replacement is attained by this method was confirmed by normal values on each determination during diuresis.

Monitoring of serum magnesium levels and consistent replacement is essential, for the loss of this ion caused by furosemide can be profound. The single low value of 0.9 mEq/L obtained near the end of treatment emphasizes this fact and became clinically apparent when pulse rate had fallen to 40/minute. Unresponsive to administration of atropine, pulse rate returned to normal following parenteral administration of magnesium. While magnesium deficiency is usually manifested by tachycardia and shortened PR interval, varying degrees of delayed atrioventricular and intraventricular conduction were reported by Alexander[4] in studies of idiopathic heart disease in alcoholism. Hypomagnesemia also has been implicated in bradycardia seen in patients with protein-calorie malnutrition.[5]

Accompanying the decrease in serum calcium was a consistent rise in BUN, which fell toward normal three days post-diuresis (Figure 1). This patient clearly had impaired renal function on admission as was manifested by elevated BUN, uric acid, and serum creatinine, and by the presence of renal failure casts in the urine. Transient increases in BUN in similar patients also receiving furosemide have been previously reported.[6]

The accentuated rise in serum calcium (16.5 mg. per cent to 18.0 mg. per cent) approximately

eight hours after diuresis was instituted is most likely secondary to inadequate water replacement initially in the therapy. Furthermore, reduction in extra cellular volume has been shown to stimulate proximal tubular reabsorption of sodium and calcium.[7] Admission hemoglobin of 10.4 probably represented a hypovolemic, hemoconcentrated state, for after hydration hemoglobin was determined to be 8.3 without evidence of acute blood loss or hemolysis. The anemia was corrected to hemoglobin 11.7 and hematocrit 35 by administration of two units of packed cells.

It is of interest that such a water-electrolyte problem be undertaken in a patient with hypertension and atrial fibrillation—both representing borderline cardiac status. The fact that blood pressure remained stable and that digitalis was discontinued without sequelae during the diuresis illustrates that inadequacies of the cardiovascular system sometimes may be satisfactorily dealt with by proper fluid and electrolyte management.

Finally, note is made of the fact that in this patient serum calcium returned to normal within 50 hours of onset of treatment. After 47 hours only three of the eight cases reported by Suki et al[1] had return of calcium levels to normal ranges. It may well be that the addition of significant doses of corticosteroids in this patient contributed to the hypocalcemic effect observed. If so, this response is much more rapid than the five to seven days as reported by Mannheimer.[8] The corticosteroid dosage used here, however, is much greater than that of other workers (Mannheimer[8], Mavligit[9], methylprednisolone 80 mg. daily; Thalassinos and Joplin[10], hydrocortisone 200-300 mg. daily).

Table 1

Comparison of Urinary Sodium and Potassium Excretion Rates with Intravenous Replacement rate.

	Urinary Excretion (mEq/L)		*Replacement (mEq/L) with 4:1 Flow Rate (1000 cc NS + 20 mEq KCl: 1000 cc D₅W)*	
	Na	*K*	*Na*	*K*
Suki et al[1]	90-120	10-20	123	16
Present Case	118-136	13.3-17.5	123	16

The use of furosemide with or without corticosteroids in the acute treatment of hypercalcemia deserves attention and further clinical trial. A combined regimen of furosemide and corticosteroids was used with the hope that inhibition of the malignant process by steroids would augment the hypocalcemic effect of massive diuresis. The apparent degree of safety and effectiveness with which this program may be carried out suggests a satisfactory method of treatment of hypercalcemia. The need for adequate hydration, as well as careful replacement of Na, K, and Mg must be re-emphasized, however.

Summary

Hypercalcemia in a patient with multiple myeloma was treated with massive furosemide-induced diuresis augmented by the use of large doses of Methylprednisolone. A total of 2080 mg. of furosemide was administered intravenously over a three-day period with the only adverse effect seen being that of a transient rise in BUN. Fluid and electrolyte balance was maintained without difficulty. Mental status progressively improved as serum calcium decreased from 16.5 mg. per cent to 9.9 mg. per cent at the end of diuresis.

A list of references may be obtained by writing The Journal.

Treatment of Injuries to the Low Back

Howard A. Swart, M. D.

I have been impressed for many years with the fact that acute low back injuries generally are not regarded as being serious.

These injuries usually occur in industry. The patient gives the history of lifting some object and feels something tear or "give" in his back. He does not have a great deal of pain then, but the pain gradually comes on during a working day. He generally is able to finish out the day.

He may work for a few days more. Some morning, however, he will find that he cannot get out of bed because of severe pain in the back. He then goes to his doctor who gives him some pain medicine and who may or may not order some form of heat and a hard bed. This treatment is usually administered on an out-patient basis.

His employer may tell him to come out to work and sit around to avoid a lost-time accident.

Many of these so-called back strains clear up to the point that the man may return to work; however, his back is never the same afterward and he is prone to subsequent injury.

In many cases, however, he cannot work and pain develops in one or both legs. This is sciatic pain and its treatment is much more difficult.

At this point he is generally sent to an orthopedic surgeon for consultation. He is then put in a hospital for treatment by means of a hard bed, pelvic traction and physical therapy followed by a low back belt, or is simply given a belt at the beginning.

He may or may not get better. Some men do respond to this conservative treatment and return to work. Others do not and have to be operated on for a ruptured disc.

The back is never anywhere near normal after that. Both in the operative and the nonoperative cases, the back is prone to further injury. If a recurrence of the severe low back and leg pain results and a second disc operation is necessary, then it is almost impossible to make this man's back good enough to enable him to return to manual labor.

Thus I see many men, some young men in their 30's and 40's who cannot ever go back to work.

The Author

- **Howard A. Swart, M. D., 414 Medical Arts Building, Charleston.**

These are mostly coal miners, whose work is hard and is carried on frequently in a bent-over position.

I think these men should be told at the beginning how serious a seemingly low back strain can become and how much trouble it can cause from that point. If the doctor who sees these men initially would insist upon their resting in bed with boards under the mattresses or sleeping on the floor, I believe there would be many men who would avoid such serious results. The incidence of leg pain would be much smaller and thus the morbidity in general would be greatly reduced.

Many men go on to a high disability rating under the compensation law and much of this could be avoided if they had been treated adequately in the beginning.

There is another factor in that many of these men do not want to stay off from work. Their wages are so high now that they want to go back as soon as possible in order to avoid losing the money involved. The difference in what they receive from the Compensation Commissioner and what they make is great at the present time.

The golden time to treat these back injuries is at the beginning. I believe they go on to a ruptured disc to a greater or lesser degree. Unknown pain and suffering and thousands of dollars could be saved if adequate and intelligent treatment were carried out at once.

The cardinal points are:

(1) Stay off from work completely.

(2) Rest in bed with boards under the mattress or sleep on the floor.

(3) A minimum of activity until the pain is better.

(4) A low back belt or brace in the more severe cases.

Special Article

Family Practice Residency Programs*

Don L. Arnwine

In some respects these comments are in the nature of a "book report" as they emanate largely from what has been written on the subject of Family Practice Residencies. Additionally, I had some moderate exposure during what I will later describe as the "first era." Otherwise, these impressions and opinions were formed from discussions with many people who have had direct involvement in the establishment and operation of such educational ventures and from 14 years of experience in a teaching hospital.

Not everyone has the same frame of reference as to what constitutes Family Practice. To establish some common ground let me pose two questions, the answers to which come from the Residency Review Committee for Family Practice:

1. What is a Family Practitioner?:
   (a) The family physician is the first medical contact for patients, facilitating their access to medical care and to the whole health care system.
   (b) The family physician is the key to the referral process for problems beyond his scope of practice and competence.
   (c) The family physician is the integrator of health services received by his patients.
   (d) The family physician insures continuity in comprehensiveness of medical care.
2. What are the Objectives of the Residency Programs for Family Practice?:
   (a) Develop mastery of the body of knowledge appropriate to the discipline.
   (b) Refine skills in the organization and delivery of health and medical care to individuals and their families.

Background

While Family Practice Residency Programs are fairly new, I think that their development can be divided into two eras. The first era was the transition of the old general practice residency programs into family practice and the second era is the one in which we are now involved which is the creation of new residency programs from the beginning.

When the first era began it is my impression that the creation of the family practice residency programs did not have a very noble purpose. I think that it principally related to the fact that it was apparent that family practice was more voguish than general practice and, too, the pending incentives being offered by funding agencies for the creation of family practice programs. For the most part it was a name change from general practice to family practice and there was no additional philosophical commitment on the part of the faculty until such time as the Family Practice Review Committees began to rattle the cage and we had to come to grips with the basic question involving commitment and today those programs are beginning to look more like the ones that are being developed in the second era. Those programs, however, did gain some concessions and up to this point the Review Committees have not been as strict as they are with new programs.

The Requirements of a Family Practice Residency Program

As we turn to look at the requirements for creating a Family Practice Residency Program at this point in time, we, at the outset, have to recognize that this program has the same foundation as any other residency program when it comes to requirements or "the essentials." That is to say, that "the essentials" of approved residencies as published by the AMA's Division of Medical Education are applicable in this instance as they are to other programs. I will not go into details on those "essentials" as you probably have some familiarity with them since you are already involved in graduate medical education, but suffice it to say that the requirements

The Author

- **Don L. Arnwine, President, Charleston Area Medical Center, Charleston, West Virginia.**

*Presented before a meeting of the West Virginia Joint Council of Teaching Hospitals in Parkersburg on November 16, 1972.

of accreditation, those that relate to size and type of hospital, to the physical aspects of a hospital and to the teaching staff are pertinent here as are the requirements for certain specialized services such as radiology, pathology, a medical library, a high quality medical record department, etc.

As I have reviewed the requirements for a Family Practice Program, I have elicited five categories of requirements that distinguish the character of a Family Practice Program from those of other medical education programs and these five categories are:

1. The physical setting in which a major portion of the education takes place.
2. Inter-departmental cooperation.
3. The full-time director.
4. The establishment of family groups.
5. The support of the community physicians.

The Physical Setting

Whereas, almost all other residency programs simply utilize the facilities already dedicated to that particular specialty, the Family Practice Program requires some kind of a discrete physical unit. The Residency Review Committee has stated that "unless an institution can develop a model Family Practice unit in which the resident can practice under supervision, a Family Practice Residency cannot be approved by the Residency Review Committee." It is also their contention that this unit should be reasonably near the parent hospital in which the resident will care for most of his hospitalized patients.

As they describe the facility, it should be of adequate size, with enough room to provide for each resident the use of a private consultation room, an examination and treatment room or a minor operating room at almost any time he needs them. In addition, there should be an attractive and comfortable reception room, a nurse's station, and a receptionist's area, and a conference room or a library to be used for teaching purposes. If laboratory and x-ray facilities are not within the unit then they have to be readily available to the patients in some other fashion. They do not preclude this unit being in the hospital, but if it is, it still has to be a distinct entity reflecting the typical family practice office.

Insofar as staffing for this unit is concerned they require that there shall be an adequate number of secretaries, nurses, technicians and other personnel to assist with care in the "office" or the patient's home.

In practical terms what this means is that you will either have to dedicate approximately 1,000 square feet per trainee within the hospital and design it as a more or less typical physician's office or acquire a structure somewhere near the hospital of similar size that lends itself to modification for this purpose. This is clearly a commitment that you have not had to make for any of the other residency programs.

Inter-Departmental Cooperation

During the three-year span of the educational program the resident will have to have experiences provided by other specialties such as medicine, pediatrics, psychiatry, surgery, obstetrics and gynecology, as well as radiology and pathology and certain electives. It is probably possible for any of us to arrange a certain amount of rotation to those specialties but it is much more difficult for us to guarantee the quality of the experience that the resident gains there. It was this very facet of the family practice program that detracted more than any other from the quality of the training program that I was involved in before. All of those other services had their own house staff programs and the family practice resident or his general practice forebearer most usually were given only "visiting" privileges rather than "participating" privileges. In other words, they were not accepted as residents of equal stature with those who were already in the department and were usually lucky to get to hold the forceps in surgery or the mother's head in obstetrics.

Ideally, there should be a philosophical dedication on the part of the people in all of these specialties toward the desirability of providing education in family practice. And, in my mind, this is where anyone should begin to put together a family practice program—by gaining that kind of philosophical commitment to family practice.

In short, the business of inter-departmental cooperation should not be viewed merely as a rotation but should be viewed as a fundamental ingredient in the success of a quality Family Practice Residency Program.

The Full-Time Director

Of the Director, the Residency Review Committee says that "he should have some experience as a family physician. He should have teaching experience in a medical school and/or teaching hospital. He should be a leader and an organizer." They say that he *is usually* employed full-time. While they use the word "usually" as you look at the unique characteristics

of this program, *I personally feel that a full-time director is an essential ingredient.* Most programs probably prosper from the presence of a full-time director but many are successful without full-time direction so I highlight this as being one of the differentials between this program and others.

Family Groups

The Residency Review Committee believes that residents will learn to be better family physicians if they can care for entire families over a sufficient period of time to develop good in-depth physician-patient and physician-family relationships. Therefore, only those families interested in being provided continuing comprehensive care should be accepted as patients into the program. People oriented into and satisfied with crisis therapy who seek the services of any physician available and only when they become ill, do not provide good teaching material for family practice residents. The Residency Review Committee further feels that it is necessary for these families to come from all socio-economic groups and that they should be assigned to each resident in order for him to develop experiences in managing all types of people.

This, then, is not too dissimilar from a small health maintenance organization and I think you can envision the administrative arrangements that would be necessary to accommodate this group of patients that would be different from the way in which you now relate to your other patients.

Support of Community Physicians

Whereas, a Residency Program in Urology, as an example, principally requires a dedication on the part of the urologists I think in view of the foregoing it can be seen that the Family Practice Program must have a much broader base. Not only a willingness on the part of other specialists to provide bona fide educational experiences upon rotation but a willingness of the specialists to accommodate to the differences in the background of a Family Practice resident as opposed to another kind of resident. In other words, the goals of a Family Practice resident as he rotates through surgery differs considerably from the surgical resident and the teacher has to accommodate himself to those differences. Not only is this important but there are a couple of other things that make this broad medical staff support necessary. First is the fact that the compilation of these family groups may deprive him of some of his past or present patients or, as a minimum, some of his prospective patients. Secondly, the medical staff must be willing to support the institution in dedicating resources for a full-time director, a discrete physical entity, rather than to dedicate those resources to existing training programs.

This really gets back to the necessity for a broad base philosophical dedication to the desirability of training family practice specialists and not just a passive attitude that allows the administration or a small group to initiate such a program. While I have stressed the necessity for this kind of a broad base support, obviously the principal support will have to come from the general practitioners (or other family practitioners) already on the staff in the Department of Internal Medicine.

Other Considerations

Inasmuch as they are not "essentials" for accreditation purposes, I have not stressed some of the other aspects but the Residency Review Committee does urge that experiences be provided in law, economics, philosophy and even politics. They also desire to see the resident involved in some kind of research especially as it relates to patient care and delivery of health services.

Summary

It seems like that the course of human events is almost always cyclical. As we progress we find that we cannot completely discard the basic ingredients that launched us on the cycle of progress in the first place and invariably we seem to work our way around, in a circle, and in some respects we might view this development of Family Practice as a step in that medical evolution. In the beginning all we had were family practitioners, albeit not nearly as skilled as those we now have, and as the science of medicine became so voluminous we foresaw the need for greater and greater specialization and eventually created a well-built house with no front door. Now as we concern ourselves with the desirability to make it possible for the public to gain entry into this house and to further know which room to go to, in some respects we seem to be returning to where we started and thus completing the cycle.

Hopefully, this review of the requirements for an approved Residency in Family Practice has helped to make the point that this is not just another training program. Hopefully, also, it has not deterred your resolve to get involved or to stay involved but if we fail to recognize the commitment and sacrifices that are necessary in order to create a quality Family Practice educational program, we will do our potential trainees and our communities a disservice rather than a service.

X-Ray Case of the Month

John F. Schwacbach, M. D., and William Richmond, Clarksburg; and Ray A. Harron, M. D., Bridgeport

John F. Schwacbach, M. D., Internist; and William Richmond, Fourth Year WVU Medical Student:

This is a 55-year-old white male with a past history of diabetes mellitus, type IV hyperlipidermia cirrhosis and chronic alcoholism. He was admitted for evaluation of headaches, recurrent intermittent vomiting and low-grade fever. Past history revealed some head trauma two weeks prior to admission. On direct questioning the patient had never been outside the North Central West Virginia area. Physical examination revealed some memory impairment, but no other abnormality. Skull films were taken which were normal. Lumbar puncture was done showing a lymphocytosis protein of 100mm per cent and glucose of 40mm. per cent. Gram-stain, cultures and India ink preparations on the spinal fluid were negative; brain scan and carotid angiograms were normal. An EEG showed diffuse slowing. Chest film is shown here.

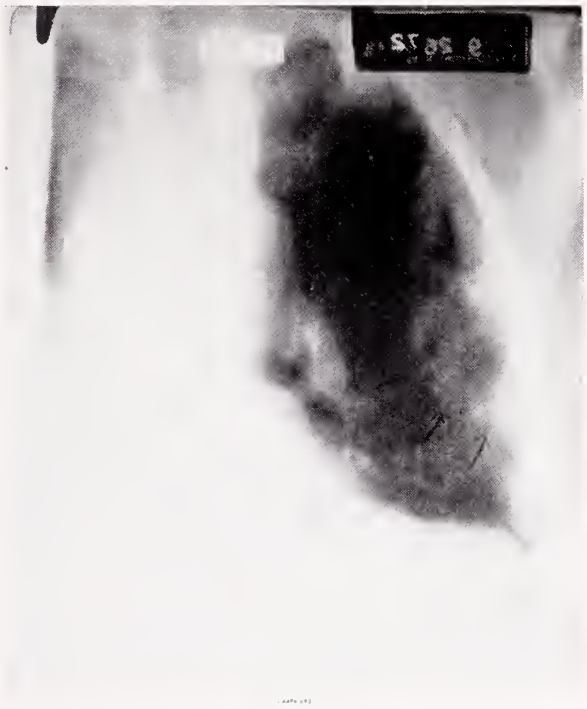

Figure 1

Ray A. Harron, M. D., Radiologist:

The chest is not remarkable except for the lateral portion of the left mid-lung field where some diffuse infiltrate is noted. A tomographic view of this area confirms the irregular nature of the infiltrate. No definite cavitation or calcification can be seen. While a neoplastic lesion such as a bronchogenic carcinoma must be considered, some type of inflammatory process would be more likely. With a lack of cavitation, the lack of pleural reaction, tuberculosis would be a less likely consideration. In view of some of the history, an inflammatory process in the lung with a secondary meningitis should be considered: cryptococcosis, malleoidosis, blastomycosis. In view of the fact that the patient has not been outside the local geographic area and in view of the fact that there is no abscess formation seen which is common in North American blastomycosis, cryptococcosis may be the most favored diagnosis.

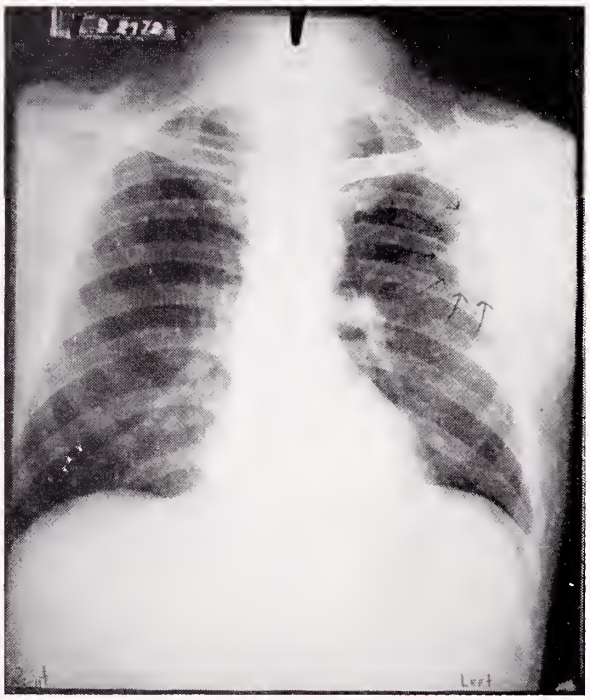

Figure 2

Doctor Schwachbach:

Repeat lumbar puncture was done. Cryptococcus neoformans was seen on direct smear and was also cultured from the spinal fluid.

Comment

Cryptoccus, also called European blastomycosis or torulosis, is world-wide in distribution and presenting symptoms are often referrable to the brain or meninges. It generally occurs in debilitated patients such as this one who had a combination of alcoholism and diabetes. While the central nervous system is frequently involved and is frequently the presenting complaint, the disease is almost always first present in the lungs. It may also involve the skin.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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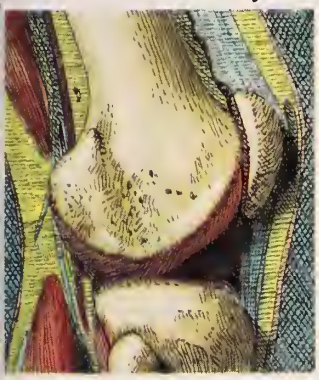

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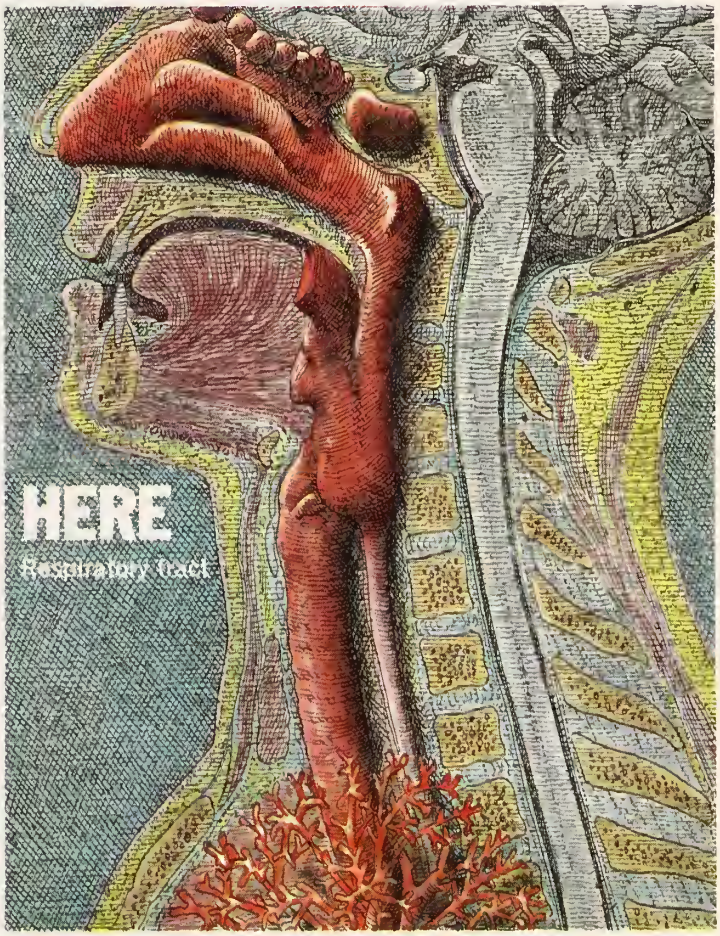

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The President

PHYSICIANS WITH TEMPORARY LICENSES

We should discourage the use of the term "foreign physician" which at best is ambiguous. Some American-born physicians are trained in foreign schools and many foreign-born physicians are trained in American schools. Although cultural backgrounds and language barriers are involved, the thorn in our sides is the *Temporary License*. Therefore, we should use the term "physicians with temporary licenses."

I have heard many comments about the "temporary license." The problem could have been avoided by limiting the temporary license to qualified physicians for short-term use until the Medical Licensing Board could grant a permanent license, but instead temporary licenses have been granted to the "physicians" who do not meet the criteria for permanent license under the medical licensing law.

Some of these "physicians with temporary licenses" have provided cheap medical labor for exploitation by sponsoring physicians and hospitals. Now with several hundred "physicians with temporary license" in the state, we have a definite problem. Many of these people are well trained and practicing high quality medicine, but some have serious language and training deficiencies and are unable to successfully pass qualifying examinations.

The Medical Licensing Board has acted wisely, although belatedly, to face the situation. The basic issue is whether a candidate for licensure is qualified to practice good medicine. If he has passed an approved English medical examination or has been certified by an American specialty board, he should receive a regular license. All candidates with approved medical training should be allowed to take the qualifying examination. All applicants for medical licensure in West Virginia should be required to have passed the FLEX or its equivalent or be certified by an American specialty board before they are licensed and before they practice in West Virginia. The medical licensing board should not be concerned with their citizenship status if they are in the United States legally.

A change in the medical licensing law may be needed.

Worthy W. McKinney M.D.

W. W. McKinney, M. D., *President*

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EDITORIALS

THE NEW LOOK IN FAMILY PLANNING CLINICS

Of the 42 patients in the county family planning clinic this third week in September, 12 were single girls: coeds from the nearby community college. Coming in groups of twos and threes these girls were not hippies. They were clean, neat and attractive, smiling and friendly. They could have been the girl next door, or a sister, or viewed from my age in life they could have been a daughter.

Of the 12, one had gone away to Washington, D. C., last year for an abortion, and more than half had used birth control pills for a few months before.

There was a determined normalcy: an everyday quality to their approach to family planning. It was September, they seemed to say, and time to prepare for the new school year. Get everything ready; books, clothes, bus tickets and birth control pills.

They ranged in age from 18, legally adults, to 22. Because of my medical training, I did not give any hint of disapproval. I conscientiously tried to be warm, friendly, courteous and to help them in their plans. I did not want to drive them away from contraception to have some of them wind up in an abortion clinic. And yet I have grave misgivings about what I see happening.

As a doctor, I have medical misgivings about the wisdom of embarking on a span of five years contraception before a family is begun. One of the girls in this group has had irregular periods since they first began at age 13. The interval varies from two months to six months. She is tall and gangly and I suspect that her irregularity is due to anovulation. Certainly the birth control pills will regulate her periods, but what will five years of ovarian suppression do to ovaries that are already not functioning well. Recent reports seem to indicate that amenorrhea following cessation of pill taking is more common for the girl who had irregular periods before taking them.

The same day I served as gynecologist for this county clinic, I did a laproscopy on a young girl who very much wanted to have children but had had several years of primary infertility. She had fimbrial occlusion of both tubes probably secondary to gonorrhea. I am familiar with the arguments that the pill does not cause promiscuity; however, I must admit that my thinking was colored by the morning's work as I watched these happy healthy girls pass through the afternoon clinic.

As a man I have misgivings and nostalgic regret. Perhaps I can illustrate this feeling best by telling of an incident that happened several

years ago. I had taken my children to the city swimming pool, and I was sunbathing on the cement at the poolside. Suddenly a boy of about nine walked past cursing like a sailor. He was using four-letter descriptions of bodily functions loud enough to be heard across the pool. I thought, "My father would have struck a grown man for using that kind of language in front of women."

My own generation would abhor the violence of striking more than the cursing, but would cling with sentimental nostalgia to the genteel courtesy of not cursing. But here in public was a child using this language with no remonstrance. Suddenly a wave of nostalgia swept over me and I was awed by the loss of graciousness and gentility from generation to generation.

These young girls in my clinic are adults. They are the vanguard of their generation. They are making choices and decisions which will give the tone and quality to their world. My children sing a song called "Color My World." I see these young adults changing mores, rejecting certain moral values and adopting others, and I recognize their right to do so. I have grave misgivings, however, about the hues and tints with which they have chosen to color my world.—*Guest Editorial by T. Keith Edwards, M. D., Member of the Staff, Department of Obstetrics and Gynecology, Bluefield Sanitarium, Bluefield, West Virginia.*

CHANGES IN VESTIBULAR APPARATUS IN OLD AGE

Presbycusis, a lessening of the acuteness of hearing, often characterizes old age. Presumably it has a distinct familial tendency. The author of this essay, for example, knows of a family of 12 children; presbycusis occurred in the father, in three sons and two daughters. The condition is generally recognized by physicians and also by many laymen. The matter of changes in the vestibular apparatus in old age, however, is much less generally appreciated and actually not much is known about this condition.

It is of interest to compare the vestibular apparatus in individuals who have a pure presbycusis with those having a more severe defect of hearing. Such a comparison was made by Chladek,[1] who examined 51 subjects aged 60 to 75 which included 27 with pure presbycusis and 24 with a more serious hearing defect. He found that the suprathreshold post-rotation excitability was reduced in both groups of patients. A central genesis of vestibular disorder was found also in both groups at a rate of 21 and 22 per cent that is, nearly one quarter of all patients who had hearing difficulties showed a disorder of the vestibular apparatus. It might be expected perhaps that those with a serious hearing defect would show a higher percentage of vestibular disorder.

It is of interest to speculate on whether patients who have a simple presbycusis and who show a lowering in excitation of vestibular activity also have some difficulty with their gait. It is possible that these may be important contributing factors. Many people complain of an unsteadiness in their gait as they grow older, and in some instances experience a considerable amount of inconvenience in walking. Unfortunately, not much can be done in these older people to relieve the vestibular disorder. The use of a crutch or a cane often gives them confidence and makes it less difficult for them to walk, and gives them greater assurance. Indeed, much more research is needed on the vestibular apparatus in older people.

1. Chladek, V. Cas. Lek. Cesk 105: 15, 1966.

Steel Guides For Nerve Growth

University of Cincinnati scientists are developing a porous, stainless-steel tube designed to be implanted as a guide for regeneration of torn nerves in patients suffering from paralysis or loss of sensory perception.

According to the National Society for Medical Research, Dr. James L. Hall and Prof. William E. Kuhn are conducting their study with rats at this time. The work is being done on the animals' peripheral nerves, specifically, the sciatic nerve in the hip area.

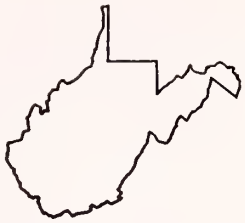
The scientists use a vacuum technique to draw the damaged nerve ends into the best position for healing within the steel tube, which is approximately one-half inch long and 1/40,000ths of an inch in diameter.

Even under the best conditions, present surgical repair techniques for torn nerves usually result in lasting damage. With the procedure under investigation at Cincinnati, the scientists expect the traumatic effect of nerve repair to be kept to a minimum.

More time and research are necessary before Prof. Kuhn and Doctor Hall proceed to higher order laboratory animals.

If the two researchers can demonstrate the feasibility of their technique in animals, clinical testing in humans may be justified. This procedure may eventually save many patients with torn or damaged nerves from paralysis and loss of sensory perception.

GENERAL NEWS



Drs. Morris and Kirkpatrick To Speak At 106th Annual Meeting

Dr. A. Thomas McCoy of Charleston, Chairman of the Program Committee, has announced that Dr. James J. Morris, Jr., of Durham, North Carolina and Dr. John A. Kirkpatrick of Philadelphia, have accepted invitations to present papers during the 106th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 22-25.

John A. Kirkpatrick, M. D.

James J. Morris, Jr., M. D.

Doctor Morris will participate in a "Symposium on New Concepts in the Medical and Surgical Treatment of Coronary Artery Disease" at the first general scientific session on Thursday morning, August 23, and Doctor Kirkpatrick will present a paper at the second general scientific session on Friday morning.

James J. Morris, Jr., M. D.

Dr. James J. Morris, Jr., Associate Professor of Medicine and Project Director of The Myocardial Infarction Research Unit at the Duke University Medical Center, is a native of Jersey City, New Jersey.

He was graduated from Hofstra College and received his M. D. degree in 1959 from the State University of New York, Downstate Medical Center, Brooklyn, New York. He interned at Duke Hospital and served residencies at that hospital and at the Veterans Administration Hospital in Durham.

He served as a member of the faculty at the Duke University Medical Center from 1964 to 1966 and in 1967 he served as Assistant Professor of Medicine at the University of Pennsylvania School of Medicine and as director of the Hemodynamics Laboratories at the University of Pennsylvania Hospital. He was certified by the American Board of Internal Medicine in 1969 and currently is a Teaching Scholar of the American Heart Association.

John A. Kirkpatrick, M. D.

Dr. John A. Kirkpatrick, who holds the positions of both Professor of Radiology and Professor in Pediatrics at the Temple University School of Medicine, is a native of Waynesboro, Pennsylvania.

He was graduated from Franklin and Marshall College and received his M.D. degree in 1949 from the Temple University School of Medicine. He interned at York Hospital in York, Pennsylvania, and served residencies at Temple University Hospital and Children's Medical Center in Boston. He served as a Lieutenant in the Medical Corps in the United States Navy, 1950-52, and was a medical officer at the U. S. Naval Academy in Annapolis, Maryland.

He has been a member of the faculty at the Temple University School of Medicine since 1956 and is a radiologist at St. Christopher's Hospital for Children and the Childrens Heart Hospital. He also is a consultant in radiology at a number of hospitals in the Philadelphia area. He was certified by the American Board of Radiology in 1956 and has served as an examiner for the board for the past three years.

He is a Past President of the Society for Pediatric Radiology and a member of the Radiological Society of North America, American College of Radiology and the American Roentgen Ray Society. He also is an Affiliate Fellow of the American Academy of Pediatrics.

Doctor Roth to Deliver Address

It was previously announced that Dr. Russell B. Roth of Erie, Pennsylvania, President Elect of the American Medical Association, will deliver an address before the first session of the House of Delegates on Wednesday afternoon, August 22. Doctor Roth will be installed as President of the AMA at the annual convention in New York City in June.

Three General Scientific Sessions

Doctor McCoy said there will be three general scientific sessions on Thursday, Friday and Saturday mornings and that meetings of sections and affiliated societies have been scheduled for the afternoon hours.

In addition to Doctor Morris, there will be two additional speakers at the symposium on Thursday morning and specialists in the fields of surgery, obstetrics and gynecology will join Doctor Kirkpatrick as speakers at the Friday morning session.

The third general scientific session on Saturday morning will be devoted to a "Symposium on Family Practice."

Serving with Doctor McCoy on the Program Committee are Drs. William H. Carter of Charleston, C. Richard Daniel of Beckley, Robert G. Janes of Fairmont and Philip M. Sprinkle and J. Hugh Wiley of Morgantown.

Useful Information Outlined By Kidney Foundation

The officers of the West Virginia Kidney Foundation have requested that the following information in re activities of the Foundation be published in *The Journal*:

The West Virginia Kidney Foundation meets approximately four times a year and at times we have information that we feel will be useful. It just occurred to us at our recent meeting that we really haven't kept in touch with the physician community in the State. If possible we would like to include in the next *Journal* the following statement:

There has been a renal amendment to the Medicare Bill which Congress passed and the President signed into law October 30, 1972. This bill is attached to the Medicare law and essentially provides for chronic dialysis and/or renal transplantation which will be insured under Social Security.

This appears to be quite extensive coverage and in order for patients to be eligible they must either require dialysis or be candidates to receive kidney transplant. A dependent of a person insured under Social Security (this includes children, husband or wife) is eligible.

Further information regarding this can be obtained from the National Kidney Foundation, 116 E. 27th St., New York, N.Y. 10016, or the West Virginia Kidney Foundation, P. O. Box 3101, Charleston, W. Va. 25331.

"Family Life" Conference

"Crisis In Family Life" is the theme of the first annual conference on the family to be held in Charleston March 2, 3, and 4 at the Heart-O-Town Motor Inn.

The conference is sponsored jointly by the American Academy of Family Physicians and the Kanawha Pastoral Counseling Center.

Principal speakers will include Edrita Fried, Ph.D., Associate Clinical Professor of Psychiatry at New York Medical College, and Training Analyst and Supervisor at the Postgraduate Center for Mental Health in New York; James Hodge, M. D., Chief of Psychiatry at Akron City Hospital, Akron, Ohio; and the Rev. William Oglesby, Ph.D., Professor of Pastoral Counseling at Union Theological Seminary in Richmond, Virginia.

The conference is designed for physicians, clergymen, and other professional people working with families.

AAFP President, West Virginia Native, To Speak At State Assembly

The President of the American Academy of Family Physicians, a native West Virginian, will speak at the 21st Annual Scientific Assembly of the West Virginia Chapter April 6, 7, and 8 at the Lakeview Inn and Country Club in Morgantown. He is Dr. James L. Grobe, a graduate of Marshall University and West Virginia University. He will speak at the Annual Banquet on Saturday night, April 7. Roger Tusken, Executive Director of the American Academy of Family Physicians, will be Toastmaster.

James L. Grobe, M. D.

Richard E. Flood, M. D.

Doctor Grobe received his M. D. Degree in 1952 from the Medical College of Virginia. He has been in a three-man family practice partnership at the Kalor Medical Clinic at Phoenix, Arizona since 1953. He is Immediate Past President of the Arizona Medical Association and a member of the American Medical Association's Council on Family Practice. Active in the field of mental health, Doctor Grobe is a member of the AMA Council on Mental Health, was on the Board of Directors of the National Association for Mental Health for two years, and is a member of the President's Joint Commission on Mental Health for Children. In 1966, he was the recipient of an award for outstanding contributions to the field of psychiatry from the Arizona Psychiatric Association.

Officers of the West Virginia AAFP Chapter include: Dr. Richard E. Flood, Weirton, President; Dr. Donald P. Brown, Kingwood, President Elect; Dr. William D. Crigger, Charleston, Vice President; Dr. John W. Traubert, Wellsburg, Secretary, and Dr. Ray M. Kessel, Logan, Treasurer.

Speakers and their topics for the Friday morning session will be as follows:

"General Nursing Today and Tomorrow"—Lorita Jenab, Dean of School of Nursing; Gaynelle McKinney, Professor and Assistant Dean of School of Nursing; Jean Hoff, Assistant Professor of Nursing, and Nancy Koontz, Assistant Professor of Nursing, all at West Virginia University.

"Family Practice Training and Community"—Fitzhugh Mayo, M. D., Professor and Chairman, Department of Family Practice, Medical College of Virginia.

"Everyday Use of Oral Contraceptives in a Busy Practice"—Tom L. Jones, Jr., M. D., Professional Staff Member, Department of Obstetrics and Gynecology, The George Washington Medical Center, Washington, D. C.

Friday Afternoon

Mary Lou Lewis, M. D., Director of the Department of Medicine of the Charleston Area Medical Center, will be Moderator for the Friday afternoon session. The program will be as follows:

"End Stage Panel on Renal Disease"—David Z. Morgan, M. D., Associate Dean, WVU School of Medicine ("Process Leading to Renal Failure");

Maryrhea Morelock, Assistant Director of Social Service on Renal Medicine, University of Kentucky College of Medicine ("Psycho-Social Problems of Patients with End Stage Renal Disease");

J. Vince McKenzie, M. D., Chief of Staff, Charleston Area Medical Center ("Conservative Management of Renal Insufficiency");

Schrae LaPlante, M. D., Assistant Professor, Department of Surgery, WVU Medical Center ("Treatment of End Stage Renal Disease Transplant").

Saturday Morning

A "Symposium in Pediatric Progress" will be held Saturday morning. The Moderator will be H. H. Pomerance, M. D., Director of the Department of Pediatrics, Charleston Area Medical Center.

"Advances in Hemotology/Onocology"—William G. Klingberg, M. D., Professor of Pediatrics, WVU Medical Center;

"Present Status of Immunizations," Thomas G. Potterfield, M. D., Pediatrician, Charleston Area Medical Center;

"Advances in Endocrinology"—Edwin R. Hughes, M. D., Department of Pediatrics, WVU Medical Center;

"Advances in Genetic Counselling"—Havelock Thompson, M. D., Associate Professor of Pediatrics, WVU Medical Center;

"Advances in the Care of the Newborn"—H. H. Pomerance, M. D.

Saturday Afternoon

Speakers and their topics for the Saturday afternoon session will be as follows:

"Office Management of Diabetes"—Jerome H. Aarons, M. D., Practicing Physician Specializing in Diabetes; Clinical Assistant Professor, University of Pittsburgh School of Medicine.

"Problems in Pediatric Cardiology"—Mary Allen Engle, M. D., Attending Pediatrician and Director of Pediatric Cardiology, The New York Hospital; Director of Pediatric Cardiology, Cornell University Medical College.

"Indications for Pacing"—Richard Goese, M. D., Resident in Cardiology, WVU Medical Center (Audio visual related to his lecture, entitled, "Implantation of a Cardiac Pacemaker and Transvenous Endo Cardial Leads").

Sunday Morning

Speakers and their topics for the Sunday morning session will be as follows:

"OB Anesthesia"—Tom L. Jones, M. D.

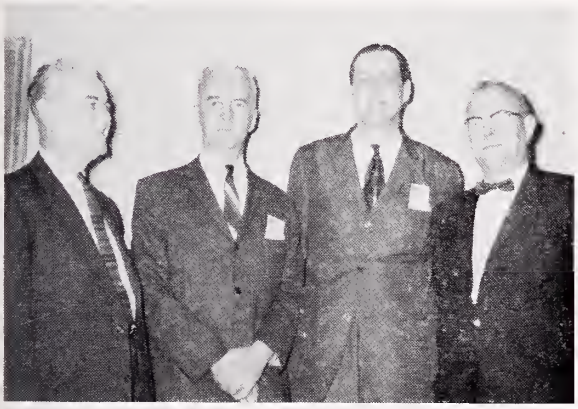
"Managing Emotional Problems"—W. W. Spradlin, M. D., Professor of Psychiatry, WVU Medical Center.

"Counselling Sexual Incompatability"—David M. Reed, M. D., Assistant Professor, Assistant Director, Division of Family Study, Department of Psychiatry, University of Pennsylvania.

There will be a meeting of the West Virginia Chapter Board of Directors preceding the general conference on Thursday, April 5, at 7 P. M.; and of the House of Delegates at 9 P. M.

The Assembly has been approved for 16 hours of credit by the AAFP.

Looking Back 10 Years . . .



Dr. John W. Hash of Charleston, left, presided at one of the scientific sessions of the 11th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice. The meeting was held at the Charleston Civic Center May 24-26. Speakers were, from left, Dr. William B. Kiesewetter of Pittsburgh, Professor of Pediatric Surgery, University of Pittsburgh School of Medicine; Dr. Leonard L. Lovshin of Cleveland, Head of the Department of Internal Medicine at the Cleveland Clinic; and Dr. L. V. Dill of Washington, D. C., Associate Clinical Professor of Obstetrics and Gynecology at the Georgetown University School of Medicine.

Maternal and Child Project

The West Virginia State Department of Health, Division of Maternal and Child Health, has been funded to provide comprehensive health services for children in eight counties.

The health services are being provided for children from conception to age six, including prenatal, delivery, and postnatal care. They will be made available to eligible residents of Braxton, Calhoun, Clay, Gilmer, Greenbrier, Nicholas, Pocahontas and Webster Counties.

The funds are provided by the Appalachian Regional Commission through the Department of Health, Education, and Welfare, and developed under the auspices of the Governor's Interagency Council and the Office of Federal-State Relations.

Expanded Clinical Conference Draws Favorable Response

The Sixth Mid-Winter Clinical Conference, held in Charleston on January 20 and 21 at the Heart-O-Town Motor Inn, drew the largest attendance of any of these mid-winter meetings. The over-all registration was 144, including 135 physicians.

Formerly known as the Conference on Chest Diseases, the conference was expanded to two days this year in order to provide more educational opportunities at one time and location for the convenience of physicians. The two-day program also provided 11 hours of training credit from the American Academy of Family Physicians, up from five hours of credit for the 1972 conference.

The revised program format drew an overwhelmingly favorable response from the participants. Of 62 physicians completing an evaluation questionnaire, 18 rated the over-all program "excellent," while 33 found it "very good," and another five graded it "good." None found it "fair" or "poor." All but two favored the expanded two-day conference.

Sponsoring groups grew from five last year to 10 this year. They were: The West Virginia State Medical Association, its Section on Orthopedic Surgery, the West Virginia Chapter, Arthritis Foundation; the West Virginia Division, American Cancer Society; the West Virginia Diabetes Association, the West Virginia Heart Association, the West Virginia Thoracic Society, the West Virginia Tuberculosis and Respiratory Disease Association, the West Virginia University Medical Center, and the West Virginia Chapter, American Society of Internal Medicine.

Program Speakers

Speakers included Allen H. Mackenzie, M. D., Staff Physician, Department of Rheumatic Disease, Cleveland Clinic; Drs. William R. Barton, Wheeling; George R. Callender, Jr., Charleston; Justus C. Pickett, Morgantown, and Thomas F. Scott, Huntington, orthopedic surgeons; Robert L. Jackson, M. D., Professor and Chairman of Pediatrics, University of Missouri School of Medicine;

J. Shelton Horsley, III, Clinical Director, Division of Cancer Studies; Professor of Surgery; Director, McIntire Tumor Clinic; Clinical Cancer Coordinator, American Cancer Society; Professor of Clinical Oncology: University of Virginia Medical Center;

Harry E. Bacon, M. D., Professor, Colon and Rectal Surgery, St. Luke's and Children's Medical Center, Philadelphia; Emeritus Professor of Colon and Rectal Surgery, Temple University Health Sciences Center;

A. K. Pfister, M. D., Charleston; Leo H. T. Bernstein, M. D., Martinsburg, President, West Virginia Chapter, American Society of Internal Medicine; George H. Khoury, M. D., Professor of Pediatric Cardiology, West Virginia University Medical Center; Robert J. Marshall, M. D., Professor of Medicine, WVU Medical Center;

N. Leroy Lapp, M. D., Associate Professor, Department of Medicine, WVU Medical Center; and Chief, Medical Research Branch, Appalachian Laboratory for Occupational Respiratory Diseases (ALFORD), U. S. Public Health Service, Morgantown; Edwin J. Morgan, M. D., Assistant Professor, Department of Medicine, WVU Medical Center; and Chief, Clinical Section, ALFORD;

Steven A. Artz, M. D., Charleston, Director of the Nuclear Medicine Department, Charleston General

Speakers at the Sixth Mid-Winter Clinical Conference in Charleston on January 20-21 included, (in the left photo) Dr. J. Shelton Horsley, III, left, Clinical Director, Division of Cancer Studies at the University of Virginia Medical Center; and Dr. Harry E. Bacon, Professor of Colon and Rectal Surgery, St. Luke's and Children's Medical Center, Philadelphia, and Emeritus Professor of Colon and Rectal Surgery at Temple University. With them is Mrs. Thelma Minter of Beckley, a former patient of Doctor Bacon who introduced him. In the right photo are, from left, Dr. A. K. Pfister of Charleston, who spoke on "Problem-Oriented Records"; Dr. Harold Selinger of Charleston, who presided at the Sunday morning session, and Dr. Joseph T. Skaggs of Charleston, Conference Co-Chairman.

Division, Charleston Area Medical Center, and James K. Sexton, M. D., Charleston Radiologist.

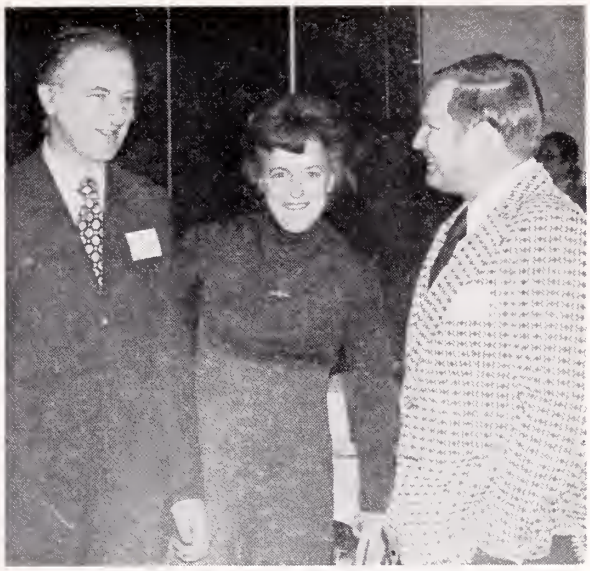
Drs. Ralph H. Nestmann and Joseph T. Skaggs of Charleston were program Co-Chairmen.

Others Attending

In addition to the 121 practitioners, 14 interns and residents, one medical assistant, three nurses, four representatives of sponsoring groups, and one drug representative also were in attendance.

Annual meetings were held during luncheon sessions by the West Virginia Thoracic Society and the West Virginia Diabetes Association. Also held in conjunction with the conference were meetings of the medical association's WVU Liaison Committee and the Ad Hoc Committee on Foundations.

It was announced that the Seventh Annual Mid-Winter Clinical Conference would again be held in Charleston, January 19-20, 1974.



Pictured here at the Sixth Mid-Winter Clinical Conference are, from left, Dr. Robert J. Marshall, Professor of Medicine at the West Virginia University Medical Center who spoke on "Pulmonary Hypertension and Heart Disease," Mrs. Marshall; and Dr. William J. Echols of Huntington.

Internal Medicine Programs Scheduled At WVU On March 31

A program on "Recent Advances in Internal Medicine" will be held on March 31 at the West Virginia University Medical Center, it was announced by Edmund B. Flink, M. D., Chairman of the Department of Medicine.

The program will begin at 9 A.M. and recess for lunch at noon. It will resume at 1:45 P. M. and conclude at 5 P. M.

Doctor Flink said all interested physicians are invited to attend. "If this is well received with good attendance, we will plan to have this as an annual event," he commented.

A luncheon will be planned at the Medical Center Cafeteria.

Workshop, Conference At UK

A Workshop and Conference on "Pulmonary Thromboembolism" will be held at the University of Kentucky Medical Center at Lexington April 19-21. The Program Chairman will be Kazi Mobin-Uddin, M. D. The registration fee will be $150 for the Conference and $100 for the Workshop. For further information, contact Frank R. Lemon, M. D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Participating in the opening session of the Sixth Mid-Winter Clinical Conference were, from left, Drs. Thomas F. Scott, Huntington; J. Hugh Wiley of Morgantown, who presided; Justus C. Pickett, Morgantown; George R. Callender, Jr., Charleston; the principal speaker, Allen H. Mackenzie, Staff Physician, Department of Rheumatic Disease, Cleveland Clinic; and William R. Barton, Wheeling. Shown in the right photo are Dr. Ralph H. Nestmann of Charleston, left, Conference Co-Chairman, and Dr. Silas C. Wiersma of St. Albans, one of the 121 physicians attending the conference.

Will Stress Molecular Basis Of Disease At ACP Session In April

The 54th Annual Session of The American College of Physicians will be held April 9-13 in Chicago at the Conrad Hilton Hotel. Special features of the scientific program will include discussions on the "Molecular Basis of Disease," most specifically in the State of the Art Lectures.

William A. Sodeman, M. D.

Dr. William A. Sodeman is President of The American College of Physicians. Doctor Sodeman was a speaker at the 16th Annual Scientific Assembly of the West Virginia Chapter, American Academy of General Practice, in April of 1968 in Charleston at the Daniel Boone Hotel.

Other special features of the scientific program will include six workshops, daily workshops on "Cardiopulmonary Resuscitation" throughout the week, and several lectures which will be taped for elective viewing in the evening on room television in most of the Chicago hotels.

The following seven scientists will present the State of the Art Lectures:

Julian Davies, "Bacteria versus Antibiotics: Who Is Winning?; Avram Goldstein, "Molecular Aspects of Narcotic Addiction;" Rachmiel Levine, "Hormonal Effects on Cell Membrane Functions;" Bert W. O'Malley, "Molecular Mechanisms of Steroid Hormone Action;" Martin Rodbell, Peptide Hormone Action and Membrane Receptors;" J. Edwin Seegmiller, "Possible Future Approaches to Correction of Human Metabolic Defects Through Genetic Engineering;" Sol Spiegelman, "Tumor Virology."

The program also will include 18 panel discussions, the presentation of 15 scientific papers, television hospital clinics, and "Meet the Professor" sessions.

Tuberculosis Decreases In State

A 10 per cent decrease in new active cases of tuberculosis was recorded in West Virginia in 1972, it was reported by Dr. N. H. Dyer, State Health Director.

During 1972, the Tuberculosis Control Program reported 248 new active cases, compared with 276 new cases during 1971, Doctor Dyer said.

During 1972, the Bureau of Tuberculosis Control took a total of 73,373 x-rays and found 2,405 abnormal x-rays. These abnormal x-rays were categorized as follows: Tuberculosis and tuberculosis suspects, 672; Tumor, 219; Cardiac, 249; Chronic lung diseases, 944; Acute lung conditions, 168; Other, 153.

As of December 31, 1972, there were 2,547 tuberculosis patients under medical supervision in West Virginia. Medical supervision for each tuberculosis case is continued for five years after the person is classified as inactive to insure that their disease is cured.

Dr. Worthy W. McKinney, President of the West Virginia State Medical Association, and Mrs. McKinney were guests of the Parkersburg Academy of Medicine and its Woman's Auxiliary at its meeting and dinner dance on January 18 at the Parkersburg Country Club. Shown here are, from left, Dr. Lyle D. Vincent, President of the Parkersburg Academy, and Mrs. Vincent; Mrs. McKinney and Doctor McKinney; Mrs. James M. Carter, President of the Parkersburg Auxiliary; Mrs. J. Dennis Kugel of Charleston, President-Elect of the State Woman's Auxiliary, and Doctor Kugel; and Dr. James M. Carter, Secretary of the Parkersburg Academy.

State Pediatrics Spring Meeting In Morgantown March 14-15

The West Virginia Chapter of the American Academy of Pediatrics will hold its spring meeting on March 14 and 15 at the Lakeview Inn and Country Club in Morgantown.

The program will open at 1 P. M. on Wednesday, March 14 with remarks by Barbara Jones, M. D., President.

Speakers and their topics from the West Virginia University Medical Center on Wednesday's program will include "Induced Chromosome Breakage," Havelock Thompson, M. D., Associate Professor of Pediatrics; "Newer Antibiotics," Albert Klainer, M. D., Professor of Medicine, and "Immunotherapy: Is It Indicated?," Robert Nottingham, M. D., Assistant Clinical Professor of Pediatrics. Also speaking will be Robert Kurucz, Ph. D., Associate Professor of Physical Education at WVU.

Thursday's session will begin with a business meeting at 8:30 A. M. Speakers and their topics will include "Adolescent Medicine: Approach and Problems," Walter Anyan, M. D., Associate Professor of Pediatrics, Yale Medical School; "Hyperactive Children: Diagnosis and Therapy," Gwendolyn Hogan, M. D., Associate Professor of Pediatrics, Harvard Medical School;

"Dyslexia," William Svoboda, M. D., Assistant Professor of Pediatrics, WVU Medical Center; "Behavior Modification," E. Wayne Sloop, Ph. D., Assistant Professor of Behavioral Medicine, WVU Medical Center.

The program will conclude with a panel discussion, beginning at 2:45 P. M., on "A Multidisciplined Approach to Dyslexia and Behavior Problems." Participating will be William Svoboda, M. D.; E. Wayne Sloop, Ph. D.; Ruth Phillips, M. D., Associate Professor of Pediatrics, WVU Medical Center, and John Kelley, M. D., Associate Professor of Pediatrics, WVU Medical Center.

Public Health Law Seminar

A seminar on the "Principles of Public Health Law and Legal Tools for Effective Health Administration in Delivery of Health Services" will be held March 12-15 at the Daniel Boone Hotel.

The seminar is sponsored by the American Public Health Association and the Southern Branch of the American Public Health Association. It is presented locally through the West Virginia Public Health Association, West Virginia Department of Health, and the West Virginia Comprehensive Health Planning Agency.

The seminar provides a new course designed to provide a constructive learning experience to public health professionals aimed at increasing an understanding and knowledge of the use of legal procedures.

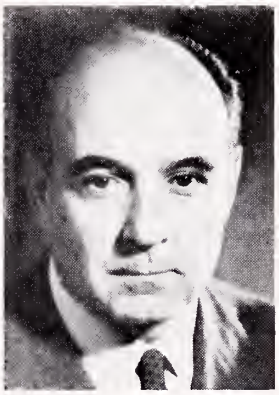
Topics will include "New and Current Trends in Public Health Law," "Individual Rights vs. Community Protection," "Legal Basis of Public Health Practice," "Basic Concepts and Principles of Public Health Law," "Legal Tools to Help Public Health Workers."

Dr. George W. Hogshead (front row, right) was installed as President of the Kanawha Medical Society at a dinner dance in Charleston on January 27 at the Daniel Boone Hotel. Other new officers are (back row, from left) Dr. G. A. Shawkey, Secretary-Treasurer; and Dr. John B. Markey, Vice President. Dr. Worthy W. McKinney (front row, left), President of the West Virginia State Medical Association, served as installing officer.

Ophthalmology, Otolaryngology Meeting at The Greenbrier

The Annual National Spring Meeting sponsored by the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier in White Sulphur Springs, April 18-21.

Dr. C. R. Davisson of Weston, President of the Academy, announced that the program will feature the following speakers in the fields of ophthalmology and otolaryngology:



Ramon Castroviejo, M. D.

Ophthalmology: Dr. Jorge Buxton, New York City; Dr. Herschell Boyd, Bellevue, Washington; Dr. Ramon Castroviejo, New York City; Dr. Donald Gass, Miami, Florida; and Dr. Gunter von Noorden, Baltimore, Maryland.

Otolaryngology: Dr. James Snow, Oklahoma City, Oklahoma; Dr. Charles Gross, Memphis, Tennessee; Dr. G. Dekle Taylor, Jacksonville, Florida; and Dr. Gene Tardy, Chicago.

Reservations for room accommodations should be made directly with The Greenbrier and a check in the amount of $75 for advance registration should be made payable to the West Virginia Academy of Ophthalmology and Otolaryngology and addressed to J. Elliott Blaydes, Jr., M.D., The Blaydes Clinic, Between North and Frederick Streets on Woodlawn Avenue, Bluefield, West Virginia 24701.

Annual OB-GYN Workshop In Charleston, May 4-5

Dr. James A. O'Leary will be among the guest speakers at the Second Annual Clinical Workshop in Obstetrics and Gynecology which will be held at the Charleston House in Charleston, May 4-5.

Doctor O'Leary is Professor and Chairman of the Department of Obstetrics and Gynecology at the Loyola University Medical Center in Maywood, Illinois.

Other members of the faculty will include Dr. Lester A. Wilson, Jr., Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Virginia School of Medicine, and Vice Chairman, District IV, American College of Obstetrics and Gynecology; and Mrs. Carole Kaufman, C.N.M., Assistant Professor of Nursing and Director of the Nurse-Midwifery Program at the Columbia-Presbyterian Medical Center in New York City.

James A. O'Leary, M. D.

Sponsors of the program will be members of the West Virginia Obstetrical and Gynecological Society; West Virginia Section, District IV, American College of Obstetrics and Gynecology; and the West Virginia Section of the Nurses Association of the American College of Obstetrics and Gynecology.

The program on Saturday, May 5, will present a discussion of the assessment of fetal maturity, laparoscopy, trophoblastic disease, prenatal genetic counseling, nurse-midwifery, and other papers by participants in the Workshop.

The morning session will be for both physicians and nurses and separate sessions will be presented that afternoon. Roundtable luncheon conferences will cover a broad series of topics of interest to clinicians.

Co-Chairmen for the meeting are Dr. Robert P. Pulliam of Beckley, and Mrs. Diane Kopcial, R. N. of Charleston. There will be a hospitality room open on Friday evening and in addition to the luncheon on Saturday there will be a dinner-dance for participants and their spouses that evening.

Overnight accommodations should be obtained by direct communication with the Charleston House, Holiday Inn No. 2, 600 Kanawha Boulevard, East, Charleston, W. Va. 25301.

Attendance at the Workshop is acceptable for credit toward the Physician's Recognition Award of the American Medical Association and additional information may be obtained by writing to Dr. Robert P. Pulliam, 120 Professional Park, Beckley, W. Va. 25801.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

March 14-15—Spring Meeting, W. Va. Chap., AAP, Morgantown.
March 14-15—W. Va. Chapter, Pediatrics, Morgantown.
March 23-24—Cancer Teaching Day, Morgantown.
March 29-30—AMA Nat. Conf. on Rural Health, Dallas.
March 31—Internal Medicine, WVU, Morgantown.

April 2-4—ACS (Spring), New York City.
April 2-7—Am. Col. of Rad., San Francisco.
April 6-7—Am. Otol. Soc., St. Louis.
April 6-8—W. Va. Chapter, AAFP, Morgantown.
April 6-8—Am. Soc. Int. Med., Chicago.
April 7-12—Am. Col. of Allergists, Atlanta.
April 8-12—Am. Assn. of Neu. Surg., Los Angeles.
April 8-13—ACP, Chicago.
April 16-18—Am. Assn. for Thoracic Surgery, Dallas.
April 18-21—W. Va. Academy of Ophth. and Otol., White Sulphur Springs.
April 23-28—Am. Acad. of Neurology, Boston.
April 25-27—Maryland Medical, Baltimore.
April 25-27—Am. Surg. Assn., Los Angeles.
April 29-May 2—Am. Soc. for Head and Neck Surgery, Hot Springs, Va.

May 2-5—ACS, W. Va. Chapter, White Sulphur Springs.
May 2-5—Am. Gyn. Soc., Colorado Springs, Colo.
May 4-5—W. Va. Ob. & Gyn. Clinical Workshop, Charleston.
May 5—W. Va. Soc. of Anesth., Morgantown.
May 7-9—Am. Col. of Sports Med., Seattle.
May 7-11—Am. Psych. Assn., Honolulu.
May 7-11—Ohio State Med. Assn., Columbus.
May 13-17—Am. Urol. Assn., New York City.
May 16-20—Am. Ped. Soc., San Francisco.
May 20-23—Nat. TB & RD Assn., New York City.
May 21-24—Am. Col. of Ob. & Gyn., Bal Harbour, Fla.
May 21-24—Am. Thoracic Soc., New York City.
May 28-30—Am. Ophth. Society, Hot Springs, Va.

June 22-23—Am. Diabetes Assn., Chicago.
June 24-27—Am. Assn. of Plastic Surgeons.
June 24-28—AMA, New York City.

Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.
Sept. 18-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 28-Oct. 4—AAFP, Denver.

Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.

Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.

Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.

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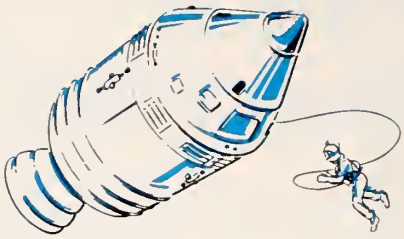

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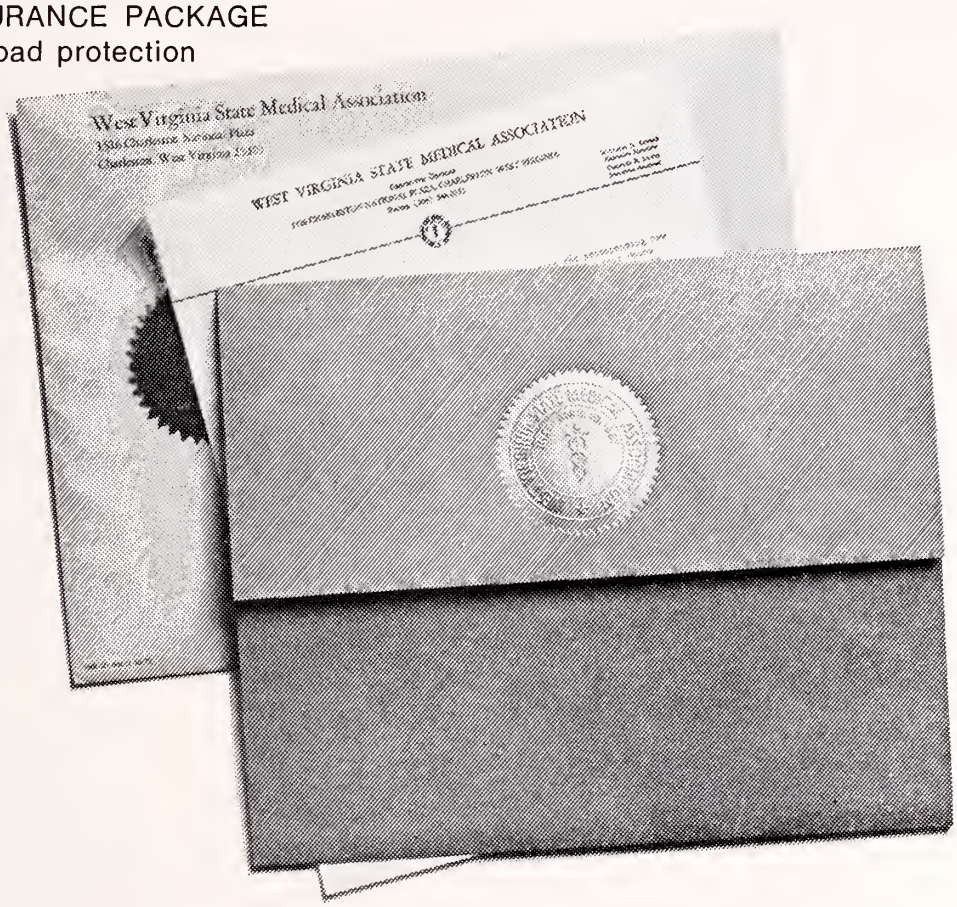

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WVU Medical Center –News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

The Ninth Annual Cancer Teaching Day, sponsored by the West Virginia University Medical Center, will be held on Friday and Saturday, March 23 and 24, in the main auditorium.

The theme will be "Skin Cancers."

Following registration at 3:15 on Friday, the conference will open at 4 P. M. with a lecture by the guest speaker, Dr. Edmund Klein, Chief, Department of Dermatology, Roswell Park Memorial Institute, Buffalo, New York.

Edmund Klein, M. D.

The program will resume Saturday morning with registration at 8:15 A. M. and a welcome at 9 A. M. by Dr. Frank McKee, Dean of the WVU School of Medicine.

Program topics and the speakers, WVU Medical Center physicians, will include "The Anatomy and Embryology of the Skin," Dr. David S. Jones; "Pathology of Skin Tumors," Dr. Jean Todd; "Etiology of Skin Cancers," Dr. William A. Welton, and "Electromicroscopy of Skin Tumors," Dr. Morton H. Friedman.

Doctor Klein will speak on "Local Chemotherapy."

Following a coffee break at 10:50 A. M., a panel of case presentations will conclude the conference. The panel members will be Doctor Klein and the following medical center physicians: Drs. Alvin L. Watne, Ray Weiss, and Alptekin Ucmakli. Dr. William Welton, Dermatology Chairman, will be Moderator.

Doctor Watne, Professor of Surgery, is Chairman for the conference.

Dr. Slack Awarded Fellowship

Dr. John M. Slack, Professor of Microbiology and former Chairman of that department at West Virginia University School of Medicine, has received a Special Fellowship from the National Institute of Allergy and Infectious Diseases.

During the period of the award, which began January 1 and will run through June 30, Doctor Slack expects to complete a monograph entitled "The Actinomycetes and Actinomycosis." Co-author is Dr. Mary Ann Gerencser, a Research Associate in the Department of Microbiology. The monograph will be published later this year by Burgess Publishing Company of Minneapolis.

The *Actinomyces* and basic studies on identification and classification of these organisms have been Doctor Slack's main research interest for a number of years.

Doctor Slack, Doctor Gerencser and their research associates at WVU were the first to use the fluorescent antibody technique as a serological method for identifying these organisms and the first to use the procedure as a direct method to aid in diagnosis of infections with the *Actinomyces* in man. Their work has resulted in a more concise classification of the species within the genus and a recognition of the classification on a worldwide basis.

More recently their research has been directed toward the identification of these organisms in the oral cavity, to aid in the determination of the role of *Actinomyces* in the development of caries and periodontal disease in man.

Pediatric Group Practice

Acting on a heavy response throughout its first year of operation, the Pediatric Group Practice in West Virginia University Hospital's Outpatient Department has enlarged its staff and is continuing to enroll new patients.

The purpose of the hospital's newest community service is to provide modern and complete health care for children who do not have a personal physician and who have not had routine checkups for chronic or potential problems.

Located in its own section of WVU Medical Center's first floor clinic area, Pediatric Group Practice is staffed by full-time pediatricians as well as pediatric nurse associates (registered nurses who have had additional training in the care of children).

Patients are seen by appointment in the morning and afternoon and there is little waiting because schedules are closely kept. In emergencies, however, enrolled patients are seen without appointment, and the group practice pediatricians provide night and weekend coverage for emergencies and acute illness. They also supervise the care of enrolled patients who are hospitalized at WVU Medical Center.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE American Medical Association protested vigorously against President Nixon keeping physicians under federal regulation in Phase III of the economic controls program.

A largely voluntary set of wage-price controls was substituted for all segments of the nation's economy except food, health care activities, the construction industry, and interest and dividends.

John R. Kernodle, M. D., Chairman of the AMA Board of Trustees, warned that such discriminatory treatment well could result in health care support personnel leaving the field. Physicians, he said, could not be expected to accept it.

"Controls are relaxed in other areas, yet the discrimination against physicians and some three million others who serve America's health needs is now even more sharply focused," Doctor Kernodle said in a statement. "A very real possibility exists that there will be a flight of allied, ancillary and support personnel from the health field, jeopardizing the quality of care being delivered."

Doctor Kernodle pointed out that, "even though the regulations as applied to health care were clearly discriminatory," the AMA had urged physicians to cooperate and they had done so with a result that their fees nationwide had increased by only 2.7 per cent since August, 1971, when Phase I began. This compared with 4.3 per cent for the consumer price index, 6.2 per cent for a semi-private hospital room, and 14 per cent for legal services.

Noting that controls never were imposed on lawyers or other self-employed professionals, he said that physicians now might have to reconsider their attitude of cooperation.

"Since its inception, we in medicine have made every effort to cooperate with the government's program," Doctor Kernodle said. "While the Lords of Labor walked out, we remained in the program and tried to make it work in the public interest. The results speak for themselves.

"We have received very little cooperation in return . . .

"Thirteen months ago, we urged physician compliance. In light of the . . . record, we shall now have to reconsider that advice."

Doctor Kernodle later took the AMA protest directly to President Nixon in a letter. It follows:

"The American Medical Association has applauded your Administration's efforts to stabilize prices and wages for the economy. The Association has supported the overall objectives of the Economic Stabilization Program and actively cooperated with the Cost of Living Council through the Health Services Industry Committee in the application of price controls on physicians' fees.

"A look at the physician component of the Consumer Price Index gives an example of the effect that "voluntary compliance" can have in curbing inflation. As a result of this Association's activities, physicians' fees rose only 1.7 per cent under Phase II. This constitutes one-third the rate of increases prior to the Economic Stabilization Program. In this respect, we have surpassed the original expectations of the Cost of Living Council, which called for halving the inflationary rates prior to Phase I.

"In view of our demonstrated success during the past year, you can imagine our dismay at the announcement of plans for Phase III. Although most of the economy is now expected to "voluntarily" adhere to the general guidelines of the Cost of Living Council, the medical profession has been placed under mandatory regulations. Indeed, the medical profession has once again been singled out under special controls. The physicians of America will not accept such discriminatory treatment. This profession must not become the victim of efforts to curb inflation in the more expensive components of the health care industry, which due to their internal financial structure have been unable to decelerate increases in their prices.

"The record of the past year clearly demonstrates that physicians are able to effectively control their fees through voluntary action. The record of the past year is equally clear that physicians' fees have not been an inflationary factor in health care costs. We, therefore, request that the medical profession be exempt from special regulations under Phase III, and respectfully request an early opportunity to visit with you on this and other matters of critical importance to the nation and the medical profession.

AMA Medicredit Bill Introduced

Some 126 senators and congressmen have introduced an improved and expanded version of the American Medical Association backed Medicredit bill for national health insurance.

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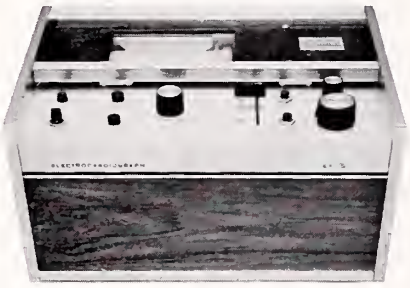

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Obituaries

HENRY L. CRISS, M. D.

Dr. Henry L. Criss of Fairmont, one of the state's oldest practicing physicians, died unexpectedly on February 4 after being taken to a Fairmont hospital. He was 92. Doctor Criss had practiced in Fairmont for more than 62 years in the same location, the McCrory Building. He was in his office on the day preceding his death.

He was born on June 23, 1880 at Lumberport in Harrison County. His family moved to Big Run, near Mannington, where Doctor Criss attended Marion County schools.

He graduated from Fairmont Normal School and taught school for a year before entering Baltimore Medical College, now the University of Maryland. He received his M. D. Degree there in 1905. After graduation, he practiced in Rymer (Marion County) before moving his office to Fairmont in 1910.

Doctor Criss was a member of the staff at Fairmont General Hospital and was a former City Health Officer for Fairmont. He was a member of the Marion County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Survivors include the widow; a son, Dr. James T. Criss, a Fairmont dentist; a daughter, Mrs. Nina Marie Lyon of Clarksburg; six grandchildren and two great-grandchildren.

Medicolegal Symposium in Las Vegas

The 1973 National Medicolegal Symposium will be held March 22-25 in Las Vegas, Nevada at the Las Vegas Hilton. The symposium is jointly sponsored by the American Bar Association and the American Medical Association. The registration fee is $45 per person, including a luncheon on Saturday, March 24, and one copy of the Proceedings of the Symposium, when published.

Speakers will include Dr. Carl A. Hoffman of Huntington, AMA President.

The symposium is acceptable for 15 credit hours in Category 2 for Physicians Recognition Award of the AMA.

For additional information, contact: 1973 Medicolegal Symposium, American Bar Association, 1155 East 60th Street, Chicago, Illinois 60637.

Change of Address

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County Societies

CABELL

Dr. Leslie F. McCoy spoke on "Disability's Extended Syndrome" at the meeting of the Cabell County Medical Society on February 8 in Huntington at the Hotel Frederick. Doctor McCoy is Director of Medical Services of the State Department of Vocational Rehabilitation.

Mr. Mike Taylor, Coordinator of the Professional Liability Insurance Program for the West Virginia State Medical Association and representing Aetna Life and Casualty Company, explained the new insurance package for association members.

Drs. John R. Parsons and James A. Heckman were appointed to the Board of Trustees of the Cabell Huntington Hospital.

Drs. Jack O. Sheppe and Marion C. Korstanje were elected to serve as Trustees to the Norval Carter Trust Fund.

Dr. Sally Oakes was admitted as a new member of the Society.—Charles H. McKown, Jr., M. D., Secretary.

* * * *

McDOWELL

Mr. Randy Swecker, Medicare Representative, was guest speaker at the meeting of the McDowell County Medical Society on January 10 at Doctors Memorial Hospital in Welch. Mr. Swecker spoke about the new systems of processing medical claims under Medicare.

The Society voted to support the resolution of the West Virginia State Medical Association urging repeal of the smallpox vaccination law in West Virginia. The Society also voted to invite Mr. Mike Taylor to attend a future meeting to speak about the new professional liability insurance package for association members designed by the Aetna Life and Casualty Company.

Dr. Charles F. McCord was appointed Acting Treasurer due to the illness of Dr. Freeman L. Johnston.—Emilio Delgado, M. D., Secretary.

* * * *

MERCER

Charleston Attorney George Daugherty was the guest speaker at the meeting of the Mercer County Medical Society on January 15 at the University Club in Bluefield.

Dr. A. J. Paine, President, introduced Dr. Edward Flynn, who had recently joined the Bluefield Sanitarium.

Mr. Daugherty, who talked about malpractice suits, recommended that all doctors review the American Medical Association legal pamphlets and obtain a copy of the Citation published by the AMA Legal Department. He called for closer cooperation

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Roentgenology:
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between physicians and lawyers, discussed the concept of informed consent, and urged that doctors maintain good rapport with patients as a deterrent to malpractice suits.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

The Monongalia County Medical Society met on January 2 at the Lakeview Inn and Country Club at Morgantown. Dr. Catalino Mendoza of the Veterans Hospital in Clarksburg was guest speaker. Doctor Mendoza spoke about his trip to Brazil with Project Hope.

The Society accepted a report of the Public Health Committee given by Dr. Isaiah A. Wiles. The report, dealing with finding solutions to the problem of teenage pregnancy, included a resolution that a statement of the problem be sent to all West Virginia Medical Societies with a request for comments and recommendations to be forwarded to our Society.

Dr. Orlando Gabriele, who is a new member of the Society, was introduced and recognized by the membership.

It was voted to request Mr. Mike Taylor of Charleston to appear at a future meeting of the Society to discuss the new professional liability insurance package for association members.—H. Summers Harrison, M. D., Secretary.

Rheumatic Diseases Symposium At Louisville In April

The ninth Annual Symposium on Rheumatic Diseases, jointly sponsored by the University of Louisville School of Medicine and the Kentucky Chapter of the Arthritis Foundation, will be held Thursday, April 19, 1973 in the Health Science Center auditorium, University of Louisville School of Medicine.

Dr. David H. Neustadt, Chief of Section on Rheumatic Diseases, has announced that the program will emphasize selected topics of current interest. The highlights include recent research on the mechanism of inflammation in arthritis, newer laboratory procedures useful for the diagnosis of rheumatic diseases, special radioisotopic techniques for the examination of joints, new developments in the surgery of rheumatoid arthritis, polymyalgia rheumatica and other nonarticular rheumatic disorders and newer knowledge on the epidemiology and clinical aspects of scleroderma.

The conference is an all-day meeting with lectures and panel discussions presented by faculty from the University of Louisville and guest faculty, featuring nationally known outstanding teachers and investigators.

There is no registration fee. Further information and a program are available from Kentucky Arthritis Foundation, 1381 Bardstown Road, Louisville, Kentucky 40204.

OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Boone	David E. Wallace	Madison	Harold H. Howell	Madison	2nd Wed.
Brooke	John W. Traubert	Wellsburg	James E. Wise	Follansbee	
Cabell	Thomas F. Scott	Huntington	Charles H. McKown, Jr.	Huntington	2nd Thurs.
Central West Virginia	Clemente Diaz	Richwood	Joseph B. Reed	Buckhannon	As Sched.
Eastern Panhandle	Hiram Sizemore, Jr.	Shepherdstown	Everett S. Fogle	Martinsburg	2nd Wed.
Fayette	W. B. Davis	Rainelle	Ivan H. Bush, Jr.	Oak Hill	1st Wed.
Greenbrier Valley	John J. Yaeger	Wht. Sul. Springs	Herbert L. Pope	Wht. Sul. Springs	2nd Wed.
Hancock	Dominic A. Brancazio	Weirton	James M. Garvey	Weirton	3rd Tues.
Harrison	L. Dale Simmons	Clarksburg	M. V. Kalaycioglu	Shinnston	1st Thurs.
Kanawha	George W. Hogshead	Nitro	G. A. Shawkey	Charleston	2nd Tues.
Logan	Thomas P. Long	Man	Leandro P. Galang	Logan	2nd Wed.
Marion	Robert R. Frye	Mannington	John C. Turner	Fairmont	Last Tues.
Marshall	Andrew J. Barger	Glen Dale	Daniel B. Gordon	Glen Dale	3rd Tues.
Mason	Aarom Boonsue	Pt. Pleasant	Antonio G. Sola	Pt. Pleasant	4th Tues.
McDowell	John S. Cook	Welch	Emilio Delgada	Welch	2nd Wed.
Mercer	A. J. Paine	Bluefield	John J. Mahood	Bluefield	3rd Mon.
Mingo	Alfredo R. Soliva	Williamson	Wm. H. Carter	Williamson	2nd Wed.
Monongalia	Margaret I. Stemple	Morgantown	H. Summers Harrison	Morgantown	1st Tues.
Ohio	Stephen D. Ward	Wheeling	Donald H. Hofreuter	Wheeling	4th Tues.
Parkersburg Academy	Lyle D. Vincent	Parkersburg	James M. Carter	Parkersburg	1st Thurs.
Potomac Valley	James C. Bosley	Piedmont	Carl A. Liebig	Keyser	2nd Wed.
Preston	Thomas A. Haymond	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	James A. Gardner	Beckley	R. James Yates	Beckley	3rd Thurs.
Summers	Jack D. Woodrum	Hinton	P. B. Camara	Hinton	3rd Mon.
Tygart's Valley	S. M. Santibanez	Grafton	A. Kyle Bush	Philippi	3rd Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	N. Martinsville	Monthly
Wyoming	Francisco Flores	Mullens	S. D. Reodica	Mullens	Quarterly

Nixon Health Budget Outlined, Plans End Of Hill-Burton

President Nixon plans to end the 26-year-old Hill-Burton program of federal grants for hospital construction and the regional medical program. His fiscal 1974 budget also calls for cutbacks in programs for community health centers, children's mental health and alcoholism.

Under the budget, medicare patients would have to pay an additional estimated $1.2 billion of their hospital and medical bills in the next 18 months.

Aside from medicare outlays of $12.6 billion, the federal budget for health—most of it under the Department of Health, Education and Welfare—calls for expenditures of $9.1 billion in the 12 months, an increase of $700 million over the current fiscal year which ends June 30.

Cancer Spending Increased

Some National Institutes of Health research programs would be cut back but spending on cancer would climb $91 million to $445 million, and outlays on heart and lung diseases would increase $28 million, to $250 million. Special emphasis would be placed on those types of cancer that cause the highest mortality—lung, breast, large bowel, prostate, bladder and pancreas. Heart research would focus on preventing arteriosclerosis and hypertension.

The NIH program of support for training of research scientists—now $150 million a year—would be discontinued. The federal government also would reduce its support for training nurses, veterinarians, optometrists, podiatrists, pharmacists and public health personnel. Federal support would be concentrated on training of physicians and dentists.

President Nixon's plans for cutbacks in some health expenditures were foreshadowed by two vetoes of HEW appropriation bills last year.

"My strategy for health in the 1970s stresses a new federal role and basic reforms to assure that economical, medically appropriate health services are available when needed," he said in his budget message.

Cutbacks Explained

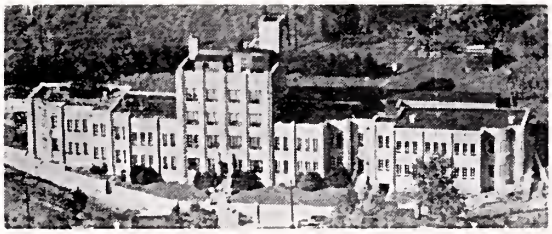
An HEW official described the cutbacks as "a conscious decision to identify those programs that have fulfilled their purposes already or are unable to." HEW officials said the regional medical program, which initially was designed to combat heart disease, cancer and strokes, never achieved its goal of providing better planning of health resources locally or speeding research knowledge into therapy. Support would be continued for the 515 centers established under the nine-year-old community mental health program but funds would not be provided to expand the number to the original goal of 2,000.

In the medicare program, the Administration is beginning to put into effect non-legislative reforms that are estimated to save the government $342 million during the remainder of this fiscal year.

The combined effect of the legislative proposals and administrative actions would be a net savings to the federal government in fiscal year 1974 of $849 million, according to the proposed budget for the Department of Health, Education, and Welfare.

Effective January 1, 1974, if congress agrees:

—Those who are hospitalized would have to pay the first day's charge for room and board and 10 per cent of the charges for all hospital services thereafter. As it is now, a medicare patient pays $72—the national average cost of one day in a hospital by a medicare beneficiary—for the first day of hospitalization and nothing more until the 61st day when he begins paying $18 a day toward his charges.



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NOTICE—Grafton City Hospital is pleased to announce its affiliation with Alderson-Broaddus College as a primary institution for the training of physicians assistants and nurses. Needed to augment the medical staff are a general practitioner, internist and an obstetrician-gynecologist. New hospital will be completed within three months and the training program will start in September 1973. Salary and subsidies can be arranged. Contact Wallace B. Murphy, M.D., Chief of Staff, Grafton City Hospital, Grafton, West Virginia 26354.

FAMILY PHYSICIANS—To practice at Jackson General Hospital and in the Ripley-Ravenswood area of West Virginia. Excellent opportunities in a prosperous area with tremendous growth potential. Salary guarantee for first year. Contact Administrator, Jackson General Hospital, Ripley, West Virginia 25271. Telephone: (304) 372-2731.

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WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mayor J. Carl Rinehart, Pennsboro, W. Va.

WANTED—Excellent opportunity for qualified pediatrician; office space, equipment, staff and minimum first year's salary guaranteed by hospital. Send resume to Administrator, Pleasant Valley Hospital, Pt. Pleasant, W. Va. 25550.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

AVAILABLE—General practitioner with West Virginia license, for locum tenens every Friday and Saturday in Huntington or vicinity. Call (513) 761-8725 or contact GHF, The W. Va. Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

PHYSICIAN WANTED—An experienced practitioner to add to and work with an established group in Charleston. Excellent working conditions with regular hours and minimal night work. Liberal vacation, sick leave and holiday program. Pension plan, Social Security, and professional liability insurance coverage. Apply Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302—Telephone 346-0381 Area Code 304.

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AVAILABLE—General practitioner with West Virginia license, desires to associate with group in Huntington. Write FHG, The W. Va. Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

URGENTLY NEEDED—General practitioners and pediatricians for a community of 22,000. Large industry, good schools, 5-year-old 67-bed general hospital, including a one-year-old 14-bed pediatric section. Community situated on federal interstate and very accessible in all directions. Contact LDT, The W. Va. Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

WANTED IMMEDIATELY—General practitioner for a modern 40-bed well-equipped hospital. Income limited only by desire and ability. Write or call Administrator, Hampshire Memorial Hospital, Romney, W. Va. 26757. Phone (304) 822-3514.

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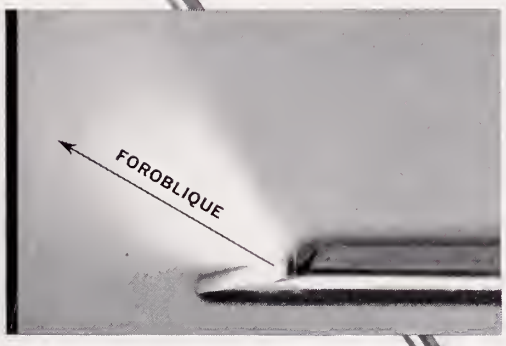

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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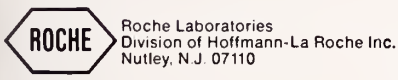

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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APRIL
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Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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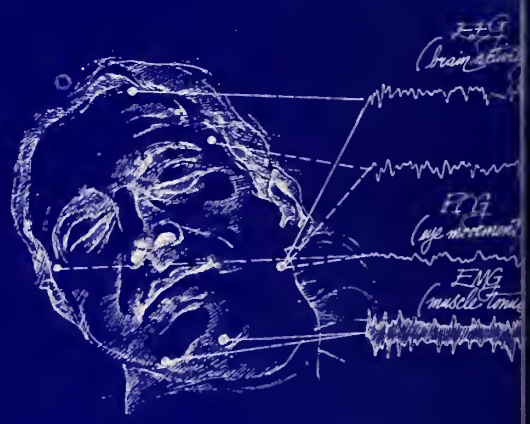

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Precautions: In elderly and debilitated, initial dosage should be limited to 15 m to preclude oversedation, dizziness and or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effec Employ usual precautions in patients who are severely depressed, or with

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Are there significant differences in bioavailability and clinical predictability among drug products?

Opinion

Results of a questionnaire to 7,000 physicians:

44.6%
Agree there is a significant difference

24.9%
Believe there is no difference

30.5%
Had no opinion

Are there significant differenc in bioavailability and clinica predictability among drug product

Teacher of Medicine

Alfred Gilman, Ph.D.
Wm. S. Lasdon
Professor & Chairman
Department of
Pharmacology
Albert Einstein
College of Medicine of
Yeshiva University

I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and hioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

Clinical Predictability More Important Than Pr

Although the questio price has been greatly aggerated, it is true t patients can on occas save money on gene drugs. But you are not ing to dare attempt to s money if it jeopardizes patient's health. Let's turn to the example t has become very promin in recent years, that of cardiac glycosides. Th are probably the most to drugs we use with resp to the small difference tween a maximally effect dose and a toxic dose. Wh you are dealing with dr of this type, the first c cern must be clinical p dictability. At the risk variations in bioavaila ity, it would be sheer fo to try to save the pati what might amount maybe $10 or $20 a ye The physician cannot m age his patient unless h sure that the drug he prescribing has the sa positive effect each ti the prescription is renew This is especially sign cant when the patient ta the product, not for mont but for the rest of his lif

Maker of Medicine

C. J. Cavallito, Ph.D.
:xecutive Vice President
Ayerst Laboratories

Although equivalence of ferent preparations of a *ug substance* may be de-ed by certain physical, emical or biological char-teristics, identity is not vays assured even though ese characteristics may described in compendia ch as the USP, NF or de-ned by other specific urce standards. More-er, even with equivalent ug substances, similar armaceutical *products* n be produced by differ-t manufacturers such at these products are bio-gically or therapeutically equivalent.

A Growing Awareness of Potential for Nonequivalence

As experience increases th drug substances de-ved from different sources d under different condi-ons, it should be possible establish specifications in fficient detail to minimize e potential for their non-uivalence. However, ere is general agreement at product therapeutic uivalence would still not assured even if one could minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequivalent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalance have appreciably improved.

Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these individuals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

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Complete literature available on request from Professional Services Dept. PML.

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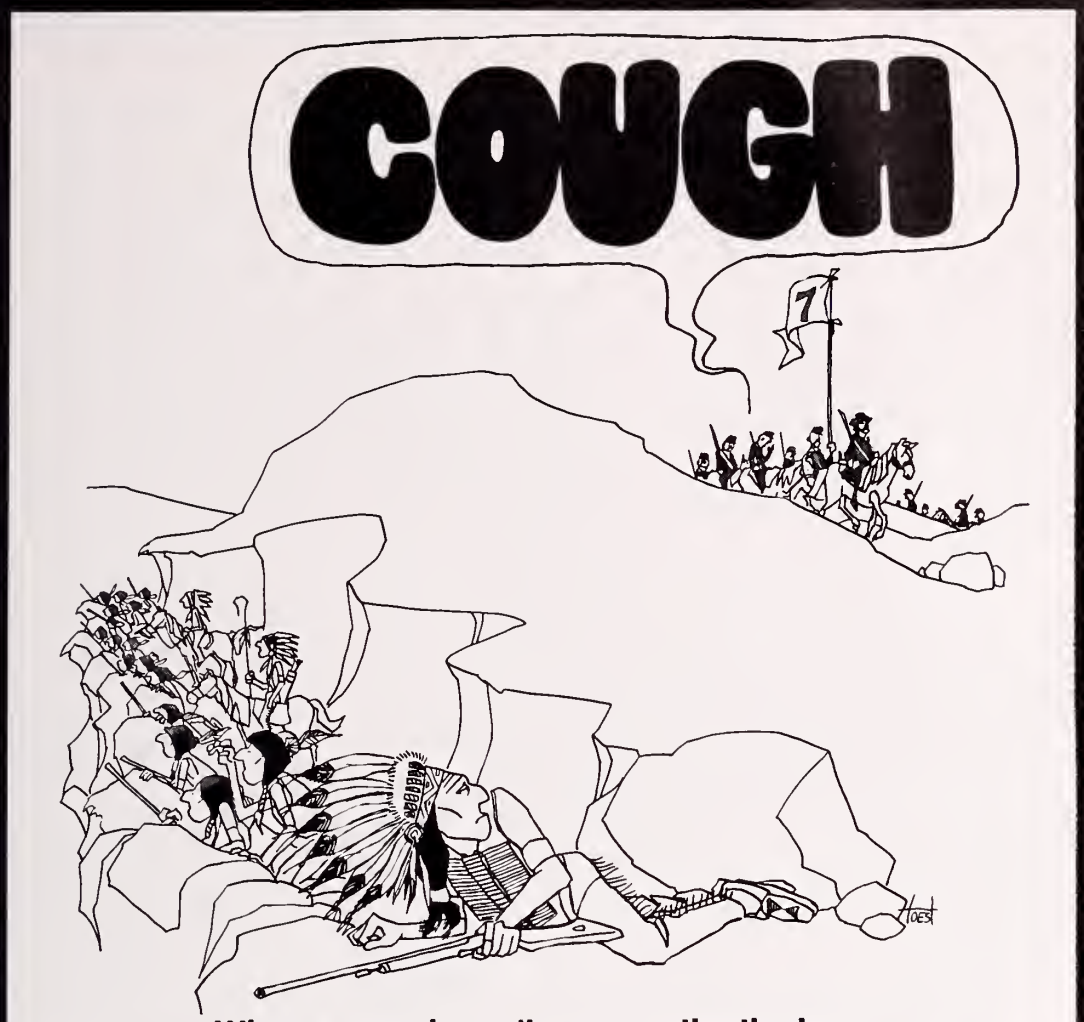

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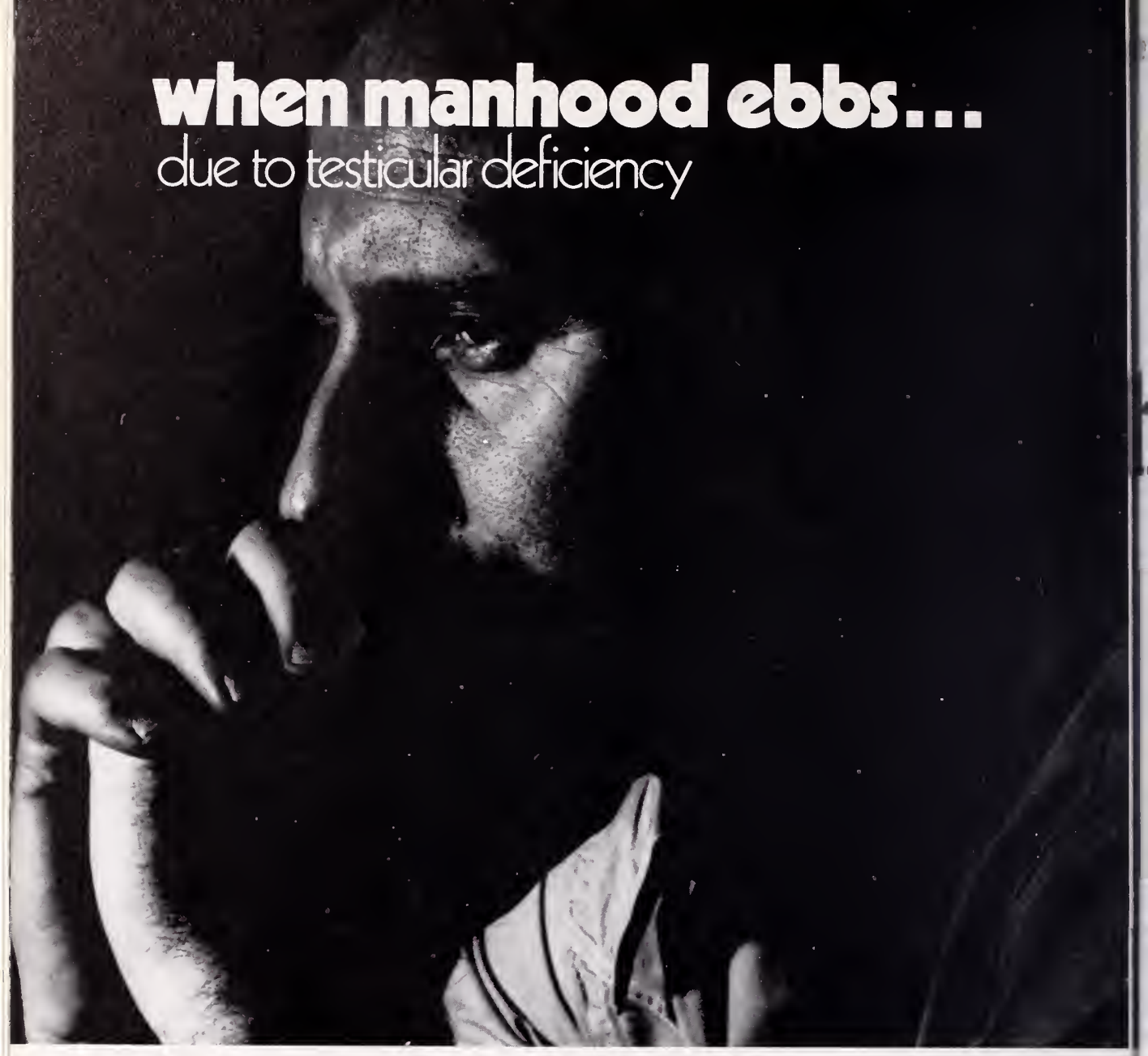

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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The West Virginia Medical Journal

Vol. 69, No. 4 April, 1973

Exstrophy of the Cloaca—Report of a Case*

Herbert H. Pomerance, M. D., and Keith M. Schneider, M. D.

Exstrophy of the cloaca is a rare anomaly which has been reported to have an incidence of about 1 in 200,000 births.[1] Although a number of reviews have appeared in the literature over the years, a completely satisfactory and explicit illustration is hard to find. The present case is reported because it provides such an illustration.

Case Report

Baby Boy Z., a premature white infant, was delivered on September 5, 1967 to a primiparous mother, age 24, sero-negative and Group B Rh-positive. There was no illness during the pregnancy, no history of intake of any medications with or without physician-consent, and no apparent reason for the premature labor and delivery. Gestation period was calculated as 37 weeks. Delivery was by breech extraction. Birth weight was 2183 Gm., length 46 cm., head circumference 28 cm. Gross examination revealed the following abnormalities, as shown in Figure 1 and schematically in Figure 2.

There was a large omphalocele, below which a large skin defect was present. Within this defect was seen a loop of small intestine (ileum), projecting cephalad, and ending in an opening which exuded fecal material. Caudad to this, another bulging area was seen, appearing to be blind colon. To each side of these two intestinal structures, there appeared to be a bladder half, each with ureteral opening within it. At the inguinal folds, two small structures representing bifid penile nubbins were identifiable, with urethral openings nearly. Just caudad to these were two structures resembling scrotal halves. Testicles were not palpable. No anus was present. There was also an equinovarus deformity of the left foot. No other clinical abnormalities were noted.

The Authors

- **Herbert H. Pomerance, M. D., Director of Pediatrics, Charleston Area Medical Center, Charleston, West Virginia; and Keith M. Schneider, M. D., New Hyde Park, New York, Associate Clinical Professor of Surgery and Chief of Pediatric Surgery, Albert Einstein College of Medicine.**

Hemogram revealed: hemoglobin 16.5 Gm. per cent, hematocrit 49 volume per cent, reticulocytes 6.1 per cent, WBC 12,100/mm^3 with normal differential and normal platelets. Serology was negative; blood group was B Rh-positive. Buccal smear revealed a negative (male) sex chromatin pattern.

The infant's condition was quite poor at birth and he became progressively weaker. Surgical

Figure 1. Photograph of patient, Baby Boy Z., on first day of life, showing exstrophy of cloaca.

*From the Department of Pediatrics, Charleston Area Medical Center, Charleston, West Virginia; and the Department of Pediatric Surgery, The Long Island Jewish Medical Center, New Hyde Park, New York.

intervention was not considered because of parental objection. Weight fell to 1673 Gm., and the infant expired on September 12, 1967, age 12 days.

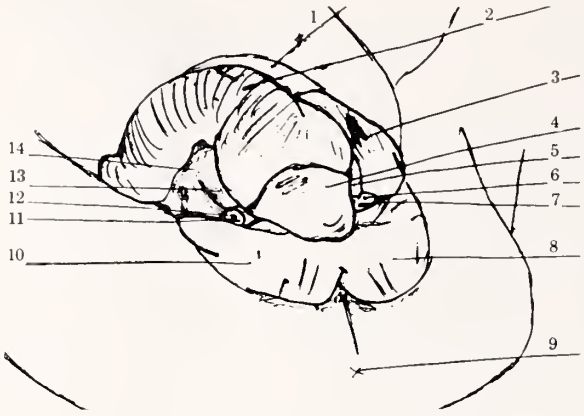

Figure 2. Schematic representation of exstrophy of cloaca, demonstrating structures seen in Figure 1, as follows: (1) Omphalocele; (2) Ileum, opening at left of drawing; (3) Left bladder half; (4) Colon, a blind sac; (5) Left ureteral orifice; (6) Urethral opening; (7) Penile tissue; (8) Left scrotal sac; (9) Absence of anus; (10) Right scrotal sac; (11) Penile tissue; (12) Urethral opening; (13) Right ureteral opening; and (14) Right bladder half.

Discussion

A number of reviews of exstrophy of the cloaca have appeared, including a rather extensive one by Spencer.[2] Attempts to explain the embryology have been made by Swan and Christensen[3] and Spencer,[2] as well as Arey.[4] Both Graivier[1] and Swan and Christensen[3] have described surgical approaches to this most serious problem. It is beyond the scope of this paper to discuss further either the embryology or the surgery. The reader with deeper need will find an excellent reference list in Spencer's paper.[2]

Addendum

Since this paper was submitted for publication, one of us (H.H.P.) has seen another identical case.

A list of references may be obtained by writing The Journal.

Reprints may be obtained by writing Doctor Pomerance at Memorial Hospital in Charleston.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

The Use of Pacemakers in Acute Myocardial Infarction

Orlando I. Agnir, M. D., and George A. Chapman, M. D.

ELECTRICAL deaths have been dramatically reduced by current management programs for acute myocardial infarction. Almost all modern general hospitals in the country have now established a coronary care unit; and the CCU has become an area of the hospital where electrical death is prevented rather than where cardiopulmonary resuscitation is performed. Ventricular tachyarrhythmias, including ventricular tachycardia and fibrillation, are easily terminated with a defibrillator, and anybody can perform this because one does not have to learn the technique of applying paddles to the chest. It is in the area of bradyarrhythmias, including heart block, however, that apparently there still are problems shared by many.

Complete heart block in acute inferior wall myocardial infarction and complete A-V block in acute anterior wall myocardial infarction are two different problems. We would like to present one example of each to illustrate certain unique problems encountered, to demonstrate the value of pacing in acute myocardial infarction, and to share with readers a technique in bedside pacemaker insertion, a technique so simple that anybody who can insert an intravenous catheter for intravenous fluids should be able to perform, even under duress.

The Authors

- **Orlando I. Agnir, M. D., Director of Coronary and Intensive Care Units; and George A. Chapman, M. D., Chief of Medical Service; both at the Veterans Administration Center, Martinsburg, West Virginia.**

Case 1

The patient is a 52-year-old white male who suffered severe chest pain for the first time on April 3, 1972. He was admitted to his local private hospital on April 6, 1972 because he had become cyanotic, dyspneic and diaphoretic. An electrocardiogram demonstrated complete heart block with a ventricular rate of 44/minute. He was given intravenous Atropine, followed by an Isuprel drip, in an unsuccessful attempt to increase the heart rate. Several attempts to insert a temporary transvenous right ventricular pacemaker electrode—initially by EKG monitoring and later under visual fluoroscopic control—also were not successful. He was transferred to the Veterans Administration Center in Martinsburg, West Virginia the following day.

He was normotensive and his pulse rate was 44/minute. His engorged jugular veins showed occasional cannon waves and there was varying intensity of the first heart sound. There was a fresh sutured incision over the right basilic vein at the right antecubital fossa, and the right radial pulse could not be felt. He had a few sticky rales heard only at the bases posteriorly.

An electrocardiogram on the day of admission, April 7, 1972, (Figure 1) showed a normal sinus rhythm with an atrial rate of 105/minute, complete A-V block with A-V junctional escape beats at 44/minute. A follow-up electrocardiogram on April 11, 1972 (Figure 2) indicated that the complete A-V block had disappeared and that small q waves could be seen in Leads II, III and AVF, suggesting inferior wall myocardial damage. Elevated serial enzymes, SGOT, LDH and CPK, supported acute myocardial necrosis. The chest x-ray demonstrated a normal heart size and mild pulmonary venous congestion.

A unipolar, teflon-coated and platinum-tipped pacemaker wire electrode was inserted through an intravenous catheter positioned in the left basilic vein. The pacemaker wire was floated down and the location of the tip was monitored by EKG. Figure 3 shows the transition of right intra-atrial electrogram to right intraventricular electrogram. When pacing could be effected, the pacemaker wire was secured to the skin. The pacemaker was then set on the demand made at 40/minute.

The complete A-V block disappeared slowly with transitional stages in the form of second, and then first degree A-V block. On the third hospital day the complete heart block altogether disappeared. The pacemaker electrode was removed on the fifth hospital day and the patient was discharged to his private physician on the 14th hospital day. His in-hospital medications included Demerol, Valium and prophylactic antibiotics only.

This case illustrates (albeit the serial electrocardiograms are not very impressive) an inferior

wall myocardial infarction complicated by complete A-V block. It was accurately predicted that the A-V block would be transient, but a pacemaker wire electrode was nevertheless inserted because it was felt that it was safer to put one in than not to insert one. He had pulmonary venous congestion and if necessary he could be digitalized safely with a pacemaker electrode in place. On the other hand, if required, cardiac inotropism could be effected by merely raising the heart rate. As it turned out, the increased atrial filling pressure generated an adequate cardiac output,

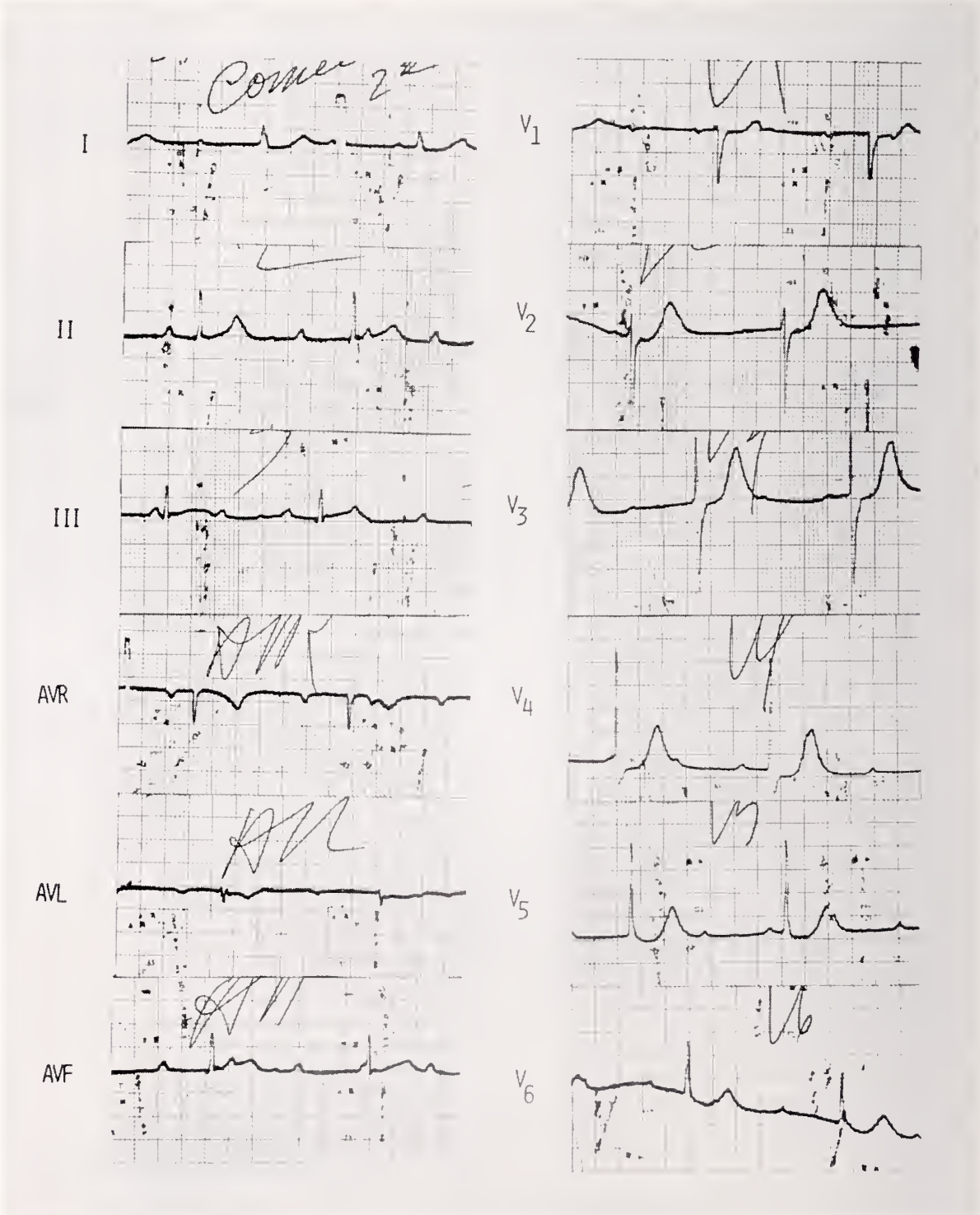

Figure I. Tracing shows normal sinus rhythm with an atrial rate of 105 per minute, complete A-V Block, with A-V junctional escape beats at 44 per minute.

and precisely because he needed the elevated filling pressure he was not given any diuretic although he had rales in the lungs.

Case 2

The patient is a 61-year-old white male who was admitted to the Coronary Care Unit on March 29, 1972 because of severe chest pain. He was extremely restless, dyspneic and cyanotic. Occasional cannon waves in the neck and varying intensity of the first heart sound suggested com-

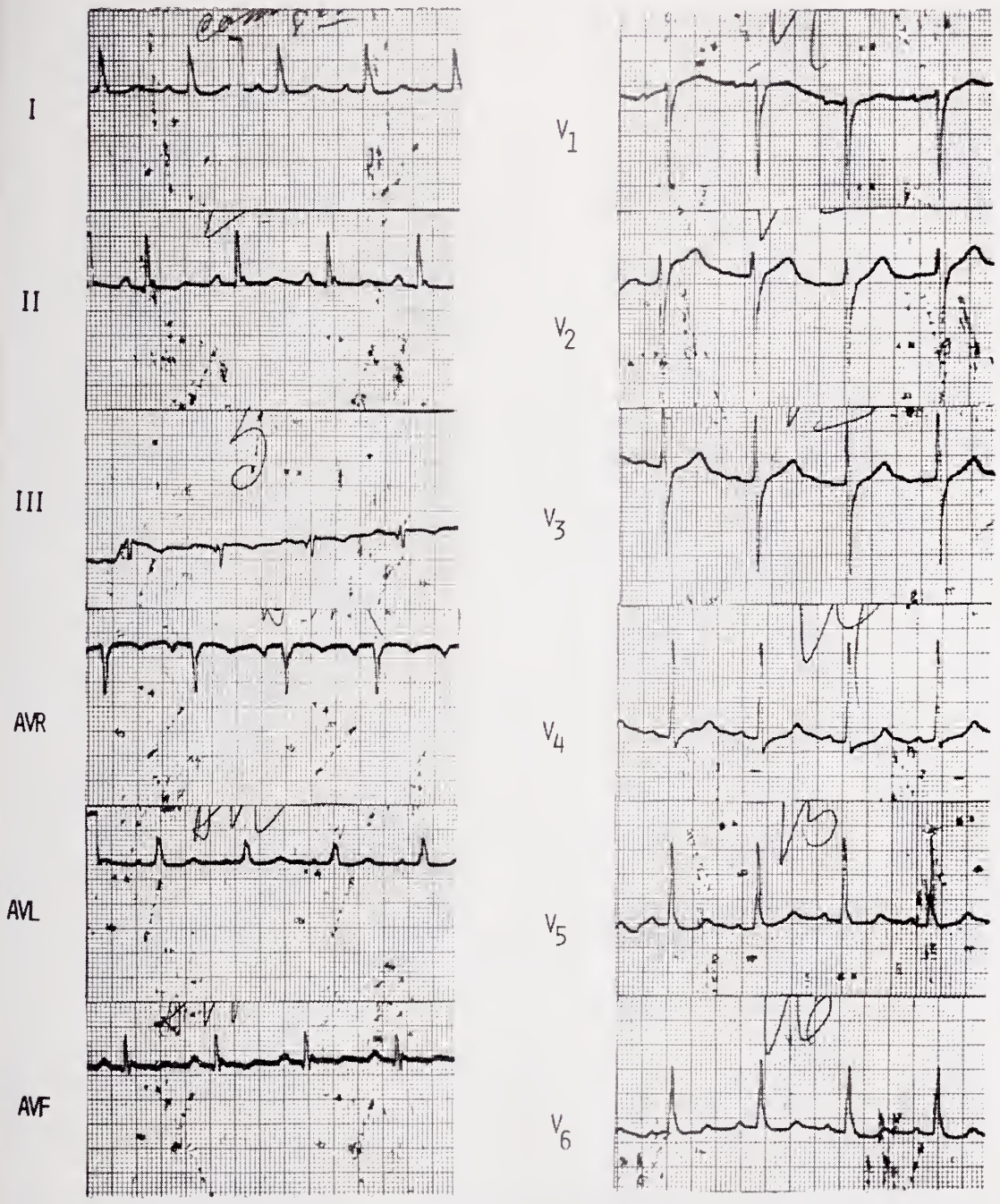

Figure 2. This follow-up EKG tracing indicates that the complete A-V Block has disappeared. Small q waves and ST-T changes in II, III, AVF can be seen.

plete heart block. An electrocardiogram (Figure 4) substantiated normal sinus rhythm with complete A-V block. The ventricular rate was 28/minute and the idioventricular escape beats showed a RBBB configuration. The T waves in V4-V6 were deeply inverted.

He was confined in the VA Center in Martinsburg, West Virginia for the first time from February 7, 1958 to February 25, 1958. Acute myocardial infarction was suspected but not proven. He had two subsequent hospitalizations —in 1959 and in 1968. In 1968, acute myocardial infarction was again suspected but not proven.

A unipolar pacemaker wire electrode was inserted through an intravenous catheter positioned in the right basilic vein. The tip of the pacemaker wire electrode was maneuvered into the right ventricular cavity. Fixed rate pacing at 65/minute was easily achieved (Figure 5). The LBBB configuration of the paced QRS indicated that the pacemaker tip was in the right ventricular cavity, and with pacemaker-endocardial contact at the right side of the ventricular septum. Marked elevation of SGOT, LDH and CPK suggested myocardial infarction. The LBBB configuration of the paced QRS almost prevented EKG confirmation of acute myocardial infarction, for it is extremely difficult to diagnose acute myocardial infarction in the presence of LBBB.[1] Accordingly, the pacemaker was slowed to 14/minute with resultant "pacemaker parasystole", and with the patient's own RBBB-like idioventricular escape beats emerging to show ST elevations in V2 to V5 characteristic of acute anterior wall myocardial infarction (Figure 6). Temporary pacing at 65/minute was continued for around two weeks and his enlarged heart shrank to normal size. A permanent transvenous pacemaker was implanted on April 17, 1972 and he was discharged on April 24, 1972 in satisfactory condition.

This patient illustrates acute anterior wall myocardial infarction with complete heart block. Location of the myocardial infarct and the idioventricular escape beats strongly indicated that the A-V block was more or less permanent. There was no doubt that a pacemaker was indicated and the only reservation was: would it do any good? It is possible that the pacemaker provided the delicate positive balance towards recovery. At a heart rate of 28/minute, and in the presence of acute myocardial infarction, the cardiac output must have been severely compromised. In this setting, it is possible that the stroke volume could not be substantially increased, and therefore the only way to increase the cardiac output to viable levels was to increase the heart rate. If this were so, without the pacemaker's increase in heart rate the patient would have proceeded inexorably to cardiogenic shock.

Discussion

There has been some controversy regarding the use of pacemakers in acute myocardial infarction. Some cardiology groups contend that no benefit is attained by inserting a pacemaker electrode in the presence of acute myocardial infarction. In the experience of Godman and his co-workers, the insertion of a pacing electrode is accompanied by frequent ventricular arrhythmias, and the complications outweigh possible benefits achieved.[2] Others like Aronson,[3] et al., however, have discovered that the pacemaker is a very important therapeutic tool in the Coronary Care Unit, representing the difference between life and death in many cases of acute myocardial infarction complicated by advanced heart block.

We take the position that pacemakers are of value in acute myocardial infarction but the pacemaker antagonists have anatomical logic. In man, the artery supplying the sinus node originates from the proximal few centimeters of the right coronary artery in approximately 55 per cent of instances and from the proximal few millimeters of the left circumflex artery in approximately 45 per cent. On the other hand, the A-V node artery originates from the right coronary artery in 90 per cent of human beings and from the left circumflex artery in 10 per cent.[4] Some collateral circulation is provided by Kugel's artery[5] which arises from the proximal right or left coronary artery. Some observers have come up with some interesting statistics:[6, 7] eight per

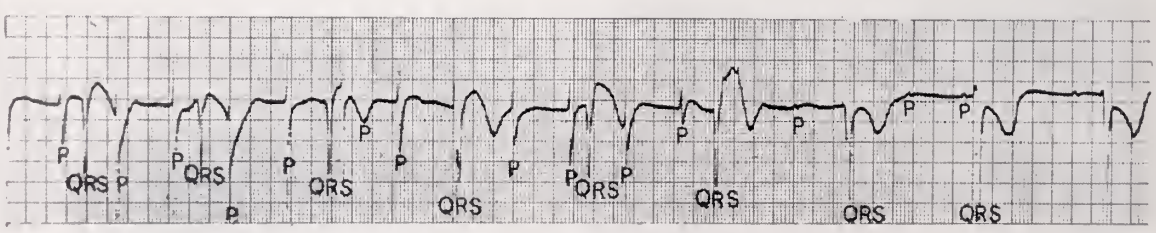

Figure 3. The above continuous tracing demonstrates the transition of right intra-atrial electrogram to right intraventricular electrogram.

cent of patients with acute myocardial infarction develop complete heart block; 30 per cent of these die of cardiogenic shock; the mortality rate of untreated cases ranges from 40 to 100 per cent. Numbers do not mean anything, however, unless the type of acute myocardial infarction is specified. For as the above review of the coronary circulation implies, occlusion of the right coronary artery or left circumflex artery will produce postero-inferior or lateral wall myocardial infarction respectively; and if transient ischemia to the A-V node occurs transient A-V block will

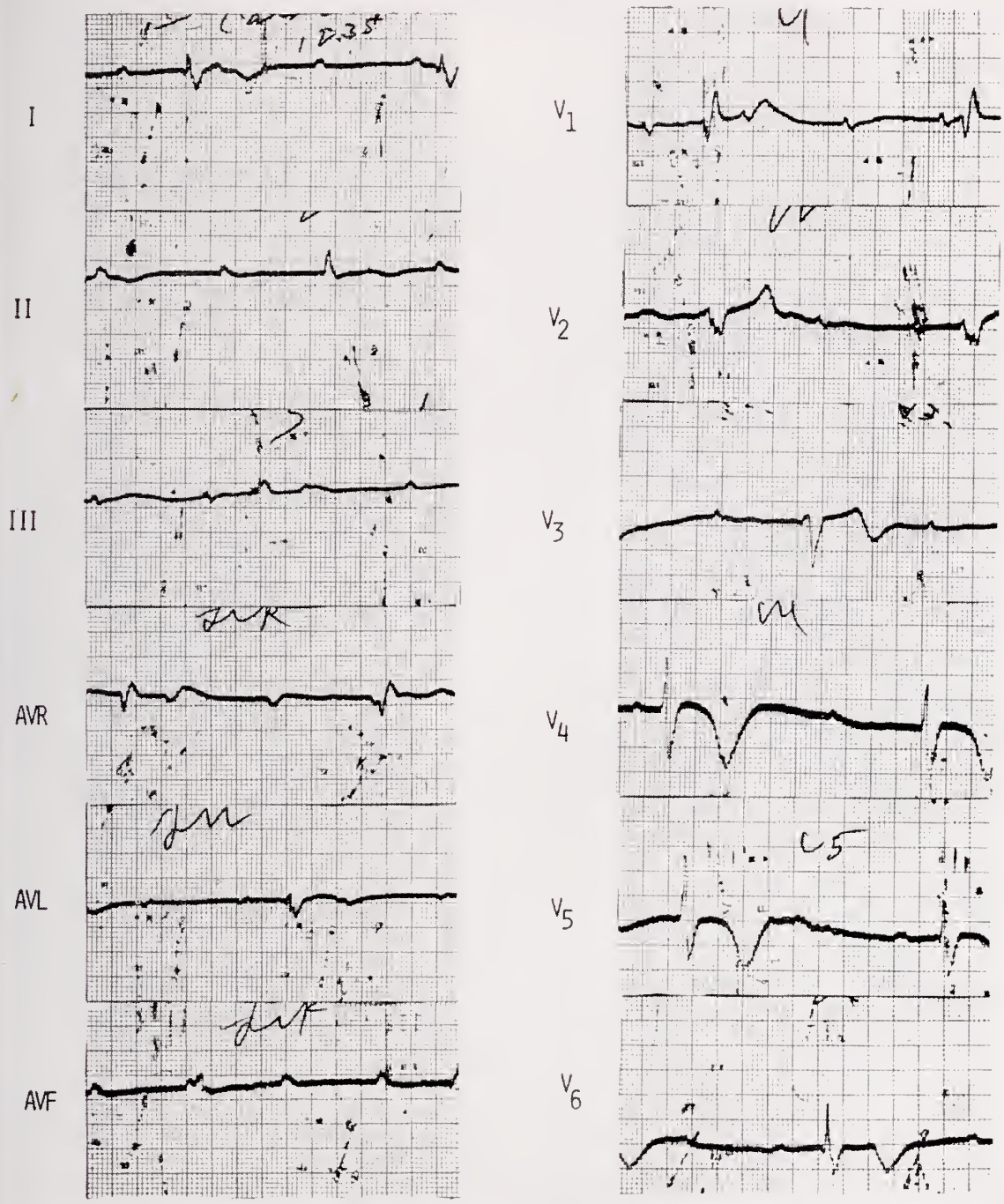

Figure 4. The electrocardiogram shows normal sinus rhythm with complete A-V Block. The ventricular rate is 28 per minute, and the idioventricular escape beats have a RBBB configuration.

follow. On the other hand, strictly anterior wall myocardial infarction indicates occlusion of the left anterior descending artery; and if high-grade A-V block develops, it is conjectured that massive infarction of the septum with involvement of the bundle of His must have ensued, in which case the patient very likely will go to cardiogenic shock because of pump failure. The literature indicates that the mortality rate in cardiogenic shock is about 80-90 per cent, but if complete A-V block attends cardiogenic shock the mortality rate climbs even higher, to 97 per cent—

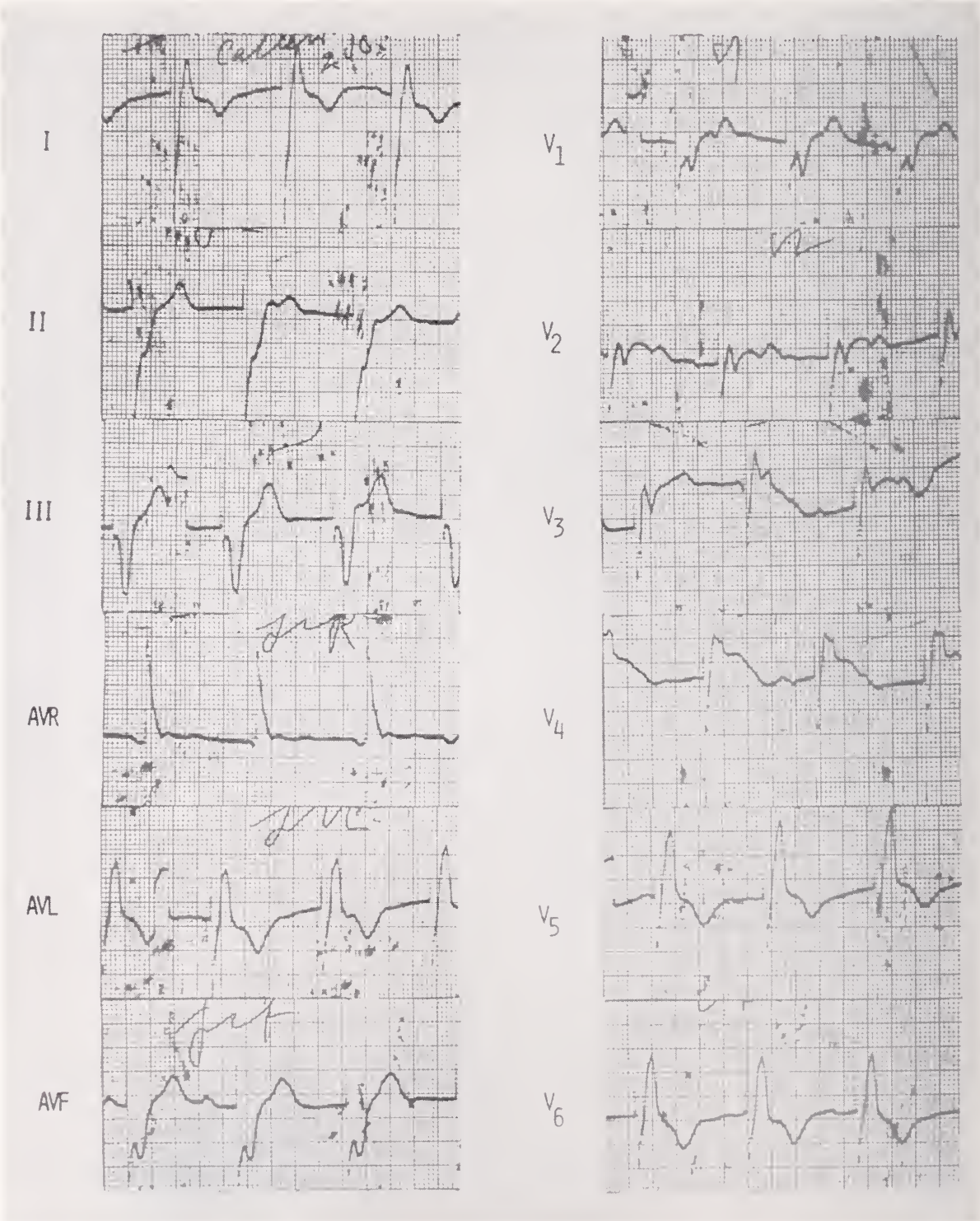

Figure 5. Fixed rate pacing at 65 per minute. The LBBB configuration of the paced QRS indicates that the pacemaker tip is in the right ventricular cavity. Depolarization begins at the right side of the ventricular septum.

with or without a pacemaker. We contend, however, as our case number 2 demonstrates—that cardiogenic shock can be prevented, when complete A-V block with a very slow idioventricular escape rate ensues, by merely increasing the heart rate.

The alternatives to pacing when severe bradycardia develops are either Atropine or Isuprel. It is now well known, however, that Atropine may cause paradoxical bradycardia or atrioventricular dissociation when small doses are used or if subcutaneous/intramuscular administration is employed.[8] Side-effects are minimized if the standard one mg. intravenous dose is employed, i.e., depression of automaticity is lessened. But the same anticholinergic effect that is desired becomes a double-edged sword if there is A-V nodal conduction abnormality or if there is A-V block

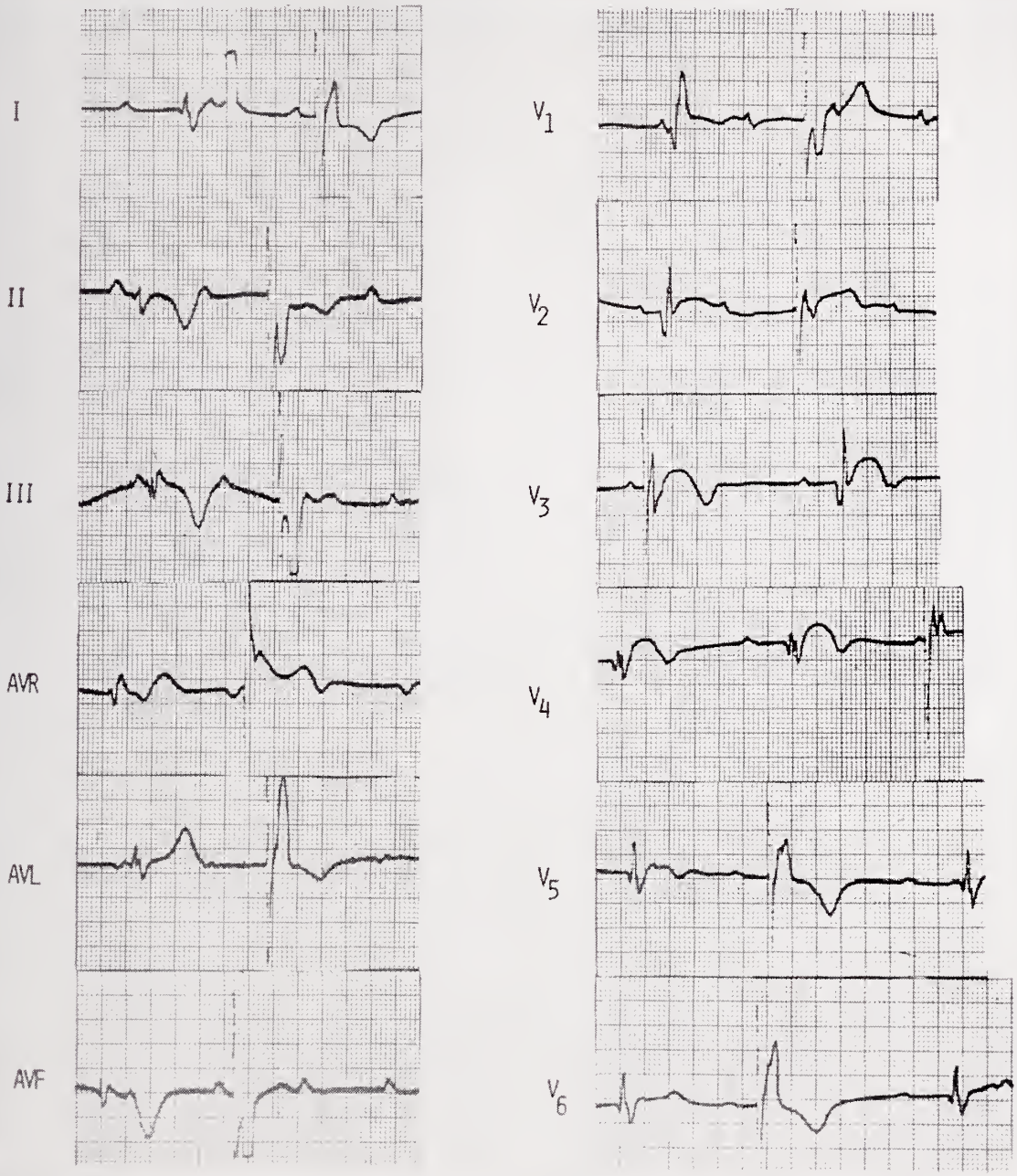

Figure 6. The electrocardiogram shows two different QRS complexes. The fixed rate pacemaker was set at 14 per minute. The third QRS complex in V_1 is a paced QRS; whereas the first two are idioventricular escape beats with ST segment elevation.

below the A-V node. For in this situation the increased sinus rate will produce increasing refractoriness in the malfunctioning His-Purkinje System or even in the abnormal A-V node—and therefore increasing A-V block.[9] The same argument holds for Isuprel.[9] In addition, the peripheral vasodilatation induced by Isuprel is deleterious in situations in which a viable blood pressure is being maintained by increased systemic vascular resistance. Understandably, we use Atropine or Isuprel in our CCU only in dire emergencies.

The easiest way to insert a pacemaker electrode obviously is with fluoroscopic visual control. There are situations, however, in which it is not safe to move the patient from the CCU to the fluoroscopy room. In our hospital, for instance, the fluoroscopy room is approximately two and one-half city blocks away from the CCU. When we insert a pacemaker electrode under fluoroscopy we almost exclusively use a 5F bipolar Elecath "semi-floating" electrode (Elecath, Rahway, N. J.). A Jelco I.V. catheter (Jelco Lab., Raritan, N.J.) is inserted into a subclavian vein and the 5F electrode is introduced through the catheter and maneuvered into the right ventricle. Initially, we monitor the tip of the pacemaker with an EKG, but if there is difficulty in introducing the pacemaker electrode into the right ventricle the patient is brought to the fluoroscopy room. The 5F Elecath electrode has some torque and can be manipulated.

Rosenberg, et al.[10] prefer the Elecath electrode over a Flexon steel wire because the latter is too light and flexible. We discovered, however, that the lightness and flexibility of the Flexon steel wire (Davis & Geck, American Cyanamid Co., Pearl River, New York) can be assets. A Bardic polyethylene 24″ catheter (C. R. Bard, Inc., Murray Hill, N. J.) is introduced into a median basilic vein percutaneously, or by open venous cut-down if necessary. The femoral vein is a suitable substitute. When the basilic vein is used and entered at the antecubital fossa approximately 18-20″ of the polyethylene catheter is introduced, and the tip becomes positioned just above the right atrium. A Flexon steel wire is then threaded through the polyethylene catheter without any difficulty. The distal tip of the pacemaker electrode is then connected to the Velectrode of an EKG and the wire electrode is floated to the right ventricular cavity (Figure 3). Tricuspid valve crossing is enhanced if the patient is made to breathe rapidly and deeply when the wire electrode reaches the right atrium. The pacemaker wire electrode is then connected to the negative terminal of the pulse generator and a 3-0 surgical steel wire imbedded in the subcutaneous tissue becomes the indifferent electrode and is connected to the positive terminal of the pacemaker. The position of the pacemaker electrode can be checked by a chest x-ray.

Summary

The cases of two patients with acute inferior and acute anterior wall myocardial infarction complicated by complete A-V block are reported. The value of pacing in acute myocardial infarction is demonstrated, and a simple technique in bedside pacemaker insertion is described.

A list of references may be obtained by writing The Journal.

Pacemaker to Straighten the Spine

A pacemaker, as most people know, is an electrical device implanted in a heart patient to regulate his heart beat. Now Canadian physicians have devised a pacemaker to straighten the spine. It is designed to, hopefully, correct the curved spine condition known as scoliosis, which affects mainly young girls. The spinal pacemaker sends out impulses which put the muscles controlling the vertebrae into intermittent spasms, forcing them into normal alignment, said Dr. Walter Bobechko of the Hospital for Sick Children in Toronto. The device has been tested successfully in animals.

The Chronic Emotionally Disturbed Patient: An Efficient Management Model

James M. Stevenson, M. D.

With the advent of phenothiazines in the mid-fifties, a major breakthrough was achieved in the treatment of the chronic, emotionally disturbed patient. Immediate effects included basic changes in particular behavioral modalities allowing the patient enough diversity of approach to his own emotional problems to return home from the state institution. Since this time many institutions have seen a decline in patient population of greater than 50 per cent, resulting, at least in part, from the utilization of this development.

The increasing number of these patients in the local population has necessitated that community mental health clinics and associations devise various means of offering further adjunctive therapy, ranging from the creation of halfway houses and "work for pay" group therapy sessions[1] to more traditional approaches.[2] The patient, however, persists in requiring followup for his drug maintenance, the principal therapeutic tool.[3] This responsibility often falls to the general practitioner who may spend several hours a month in checking these patients for drug side-effects and in writing or renewing prescriptions. The practitioner may find this a time-consuming and unfulfilling job with uncertainty about the therapeutic effect he has on this patient for the amount of time he invests.

Similarly, in the Psychiatry outpatient department of the West Virginia University Medical Center, we have been attempting to meet the needs of a large number of these chronic emotionally disturbed patients. The following approach to this problem was initiated in order to save valuable physician man hours and offer a therapeutic alternative in addition to drugs.

Method

Two groups, one of 10 patients and one of 11 patients, were chosen arbitrarily from the outpatient population. For the most part the patients' diagnoses included chronic schizophrenia, manic-depressive psychosis and psychotic depressive reaction (See Table 1). All had been institutionalized several times and were on major tranquilizers or a combination of these drugs. These patients had been followed individually by a therapist previously but had made little significant improvement. They persisted, however, in requiring medical supervision for their drug maintenance programs.

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The format was simple. The patients met together as a group[4] on a bi-monthly basis for a one-hour time period with a physician and a secretary (co-therapist). The meeting was held in a large room with seating arranged as in most doctors' waiting rooms. The physician questioned the patients individually concerning his medications and possible side-effects, significant improvements, and the need for the renewal of prescriptions. Each patient was questioned in front of the others in the group at each meeting. No attempt was made to initiate group interaction or to facilitate group process.

Results

Initially most patients objected to giving up their individual sessions with the therapist for the purpose of a "drug group." All agreed, however, to attend the sessions for a trial period. During the first meetings there was very little interaction among patients and very few reductions in medications (one patient did require an additional medication). By the third meeting the patients had taken an interest in their own maintenance program in relation to other group members' programs. A few openly expressed concern about their drug dosages as a monitor of their own particular progress. By the fourth meeting the patients reported some improvements and there were several reductions in medications. The patients were beginning to talk to each other of things other than their drug experiences, about themselves and their activities outside of the group. Several exchanged addresses and expressed intentions to contact each other outside of the hospital. After nearly 12 months of these

sessions, no patient has required re-hospitalization and many have seen significant decreases in the numbers and dosages of their medications. None has requested a return to the individual drug check appointment.

Discussion

In attempting to reduce the number of physician man hours invested in following patients whose main therapeutic program centered on medications, two drug follow-up groups met for the purpose of refilling prescriptions and checking side-effects. After nearly 12 months of these sessions over 70 man hours were conserved as patients continued to receive adequate supervision of their drug maintenance program. An unanticipated effect of these sessions was the overall improvement of the individuals concerned as reflected in some reductions in medications. Many patients took the opportunity of the group setting to improve in their interpersonal skills with the formulation of relations with other group members.[5, 6] Some have continued the relations outside of the group setting.

It would appear that in following the chronic emotionally disturbed patient, the creation of these drug groups by a physician and co-therapist (secretary or nurse) without any experience in group therapy effects a helpful therapeutic milieu for the patient while saving the physician's valuable time.

A list of references may be obtained by writing The Journal.

Table 1

Diagnosis	*Initial Medications*	*Present Medications*
Schizophrenic Reaction	150 mg. Thorazine/day 75 mg. Aventyl/day	50 mg. Aventyl/day
Schizophrenia, Mixed Type	15 mg. Stelazine/day 20 mg. Elavil/day	same
Manic-Depressive Psychosis	450 mg. Thorazine/day 6 mg. Haldol/day	300 mg. Thorazine/day
Paranoid Schizophrenia	50 mg. Elavil/day 100 mg. Mellaril/day	same
Involutional Melancholia	100 mg. Elavil/day 75 mg. Thorazine/day	100 mg. Elavil/day
Schizophrenia, Simple Type	75 mg. Mellaril/day	75 mg. Mellaril/day 100 mg. Aventyl/day
Schizophrenia, Mixed Type	40 mg. Mellaril/day 50 mg. Tofranil/day	40 mg. Mellaril/day
Paranoid Schizophrenia	20 mg Stelazine/day 75 mg. Aventyl/day	same
Schizophrenia, Chronic Undifferentiated	15 mg. Stelazine/day 25 mg. Thorazine/day	6 mg. Haldol/day
Involutional Melancholia	2-25 tid. Triavil/day	same
Catatonic Schizophrenia	15 mg. Stelazine/day 50 mg. Thorazine/day	6 mg. Stelazine/day
Psychotic Depressive Reaction	100 mg. Elavil/day	same
Depressive Neurosis	75 mg. Pertofrane/day 75 mg. Vistaril/day	no meds.
Psychotic Depressive Reaction	100 mg. Aventyl/day	no meds.
Schizophrenia, Mixed Type	20 mg. Stelazine/day	same
Manic-Depressive Psychosis	900 mg. Lithium/day	same
Schizophrenia, Chronic Undifferentiated	15 mg. Haldol/day	100 mg. Thorazine/day
Schizophrenia, Schizo-Affective Type	100 mg. Aventyl/day 6 mg. Haldol/day 20 mg. Stelazine/day	no meds.
Psychotic Depressive Reaction	50 mg. Mellaril/day	no meds.
Agitated Depression	75 mg. Mellaril/day	same
Anxiety Neurosis	4-25 mg. Triavil/qid	same

With the means at hand
) drastically reduce the number
f deaths each year from uterine
ancer, we have embarked on a
ationwide, life-saving program.
:s goal is a Pap test by 1976 for
very woman 20 years or older
) whom the test is applicable,
nd for younger women at risk.
An ambitious program, doctor,
nd one which can only be
ealized with your help.

We are faced with these
acts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

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Irreducible Inguinal Hernia Due to Carcinoma of Cecum*

Vasilios P. Dross, M. D.; Roland W. Hipsley, M. D.;
And George C. Tarasidis, M. D.

Abdominal herniation is a combination of abdominal weakness and protrusion of abdominal viscera. Many organs have been described to be present in the hernial sacs which usually are reducible. The most likely content of a hernia is small bowel, omentum or large bowel such as sigmoid or cecum. Sigmoid or cecum also could represent the lateral part of the sac of a sliding type of hernia. In spite of the fact that so much has been written about hernias, no case was found in the English literature such as the one reported in this paper. Our case is of interest because the hernia had been present for 40 years and had been always reducible until recently when anemia developed and a mass was palpated in the hernial contents.

Case Report

A 76-year-old white male was admitted to our hospital on January 11, 1966, for surgical repair of bilateral inguinal hernia. The patient was confused. He had been living in a County Home and was known to have had a "hernia for 40 years." He had fallen two or three times recently and was found to be very anemic. Therefore, on November 24, 1965, he was admitted to the local community hospital. Barium enema and G. I. series were reported normal. He was given three pints of blood and later was transferred to our hospital.

Past history was obtained from visiting relatives, who stated that the patient's father died at the age of 60 years from cirrhosis of the liver; his mother died at 81 years of age from carcinoma of the breast; one brother died at the age of 68 years from a brain tumor; another brother died at 60 years of age from carcinoma of the kidney; and a third brother died also 60 years of age from pernicious anemia.

Physical examination revealed a 76-year-old white male, anemic, and chronically ill. Blood pressure was 118/48; temperature 101; pulse 84. A huge right indirect inguinal hernia with hydrocele, and a left direct inguinal hernia were present. The right hernia was irreducible and in the contents was felt a hard, nodular mass, five by five cm. in size.

Laboratory data revealed RBC 2.8 mil. cells with hematocrit 30 volumes per cent and hemoglobin 8.5 Gm. WBC was 8,100 with 73 per cent polymorphonuclear leukocytes. Gastric analysis revealed no free hydrochloric acid. Stools were positive for occult blood. Liver function studies were normal. Chest film revealed pulmonary emphysema and fibrosis. Barium enema was again considered normal (Figures 1 and 2). The probable diagnosis, in addition to the hernias, was a coprolith in the cecum or a malignant growth. The latter was the more likely in view of the marked anemia and the positive occult blood in the stool. He received one unit of blood daily for five days. Surgery was delayed because of family problems.

The preoperative diagnosis was irreducible right inguinal hernia containing cecum, with malignancy. On February 14, 1966, surgery was performed. The findings were as follows: After the cecum was reduced by bimanual manipulation, it was found to be involved in a malignant process. The tumor was found involving the entire wall of the cecum and was attached to the distal peritoneal sac. By excising the peritoneal sac with the cecum, a limited right colectomy was done in spite of the obvious metastases to the liver and the lymph nodes. Colectomy was elected because of the anemia. The hernia on the right side was repaired extraperitoneally without any difficulties. Postoperatively, he did very well. The histopathological diagnosis was adenocarcinoma of the cecum with metastasis to the lymph nodes.

The patient was still free of anemia at the time this paper was prepared, five months after the operation.

Discussion

Inguinal hernia can be congenital or develop later in life. Any pathological condition that increases the intra-abdominal pressure could be a cause for herniation. Chronic coughing associated with emphysema, chronic bronchitis, or car-

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*From the Department of Surgery, Veterans Administration Hospital, Butler, Pennsylvania.

Figure 1

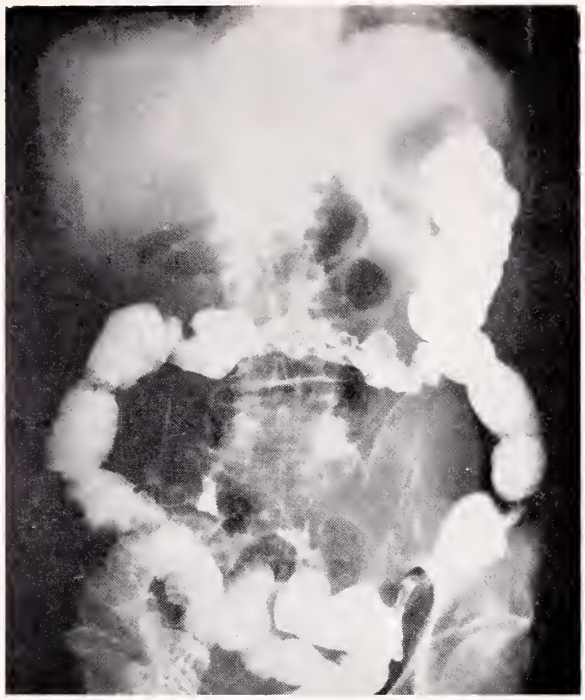

Figure 2

cinoma of the lung can be the direct cause of hernia development. We had patients admitted to our hospital for repair of recently developed hernia who were found to have carcinoma of the lung. Before any hernia repair a chest x-ray is mandatory, and any chest disease should be treated first. Urinary obstruction is another cause of increased intra-abdominal pressure. Again, the urinary obstruction should be treated first before repair of the hernia. A lesion in the colon, especially on the left side, tends to produce obstruction and so increases the intra-abdominal pressure, and thus development of hernia. Careful history and adequate work-up to exclude any cause that could increase intra-abdominal pressure should be done before a hernia repair.

Several pathological conditions have been reported to be associated with strangulation or incarceration of a hernial sac content. N. R. Hira[1] reported two cases of inguinal hernia; one was irreducible and due to leiomyoma of the ileum, and the other was strangulated due to ileocecal intussusception. Jackson,[2] in 1964, reported a case of strangulation and perforated stomach in an inguinal hernia. Campbell[3] reported a case in 1927 with preoperative findings similar to ours. At operation it was found to be a ventral hernia with cecum and appendix in the sac. The hard mass that was felt preoperatively was thought to be a fecalith. Maxwell,[4] in 1965, reviewed colon carcinomas and inguinal hernia at the V. A. Hospital, Pittsburgh, and found that 49 out of 218 patients with carcinoma of the colon, rectum, or anus had inguinal hernias, or had undergone herniorrhaphies within two years. Statistically, this seems to be significant and represents 22.5 per cent of all colon carcinomas associated with hernias. This statement applies to the older population. Wybert[5] reported a case of strangulated inguinal hernia containing cecum and ileum. This patient died and at autopsy a gangrenous area the size of a penny was found in the cecum, and the cecum contained a tumor that had invaded the surface and was attached to the hernial sac. They noted that no fibrinous adhesions or parietal colonic adhesions were present. This case is similar to ours except for the strangulation. We think that in our case the development of the carcinoma of the cecum made the hernia irreducible.

Summary

1. A case of irreducible inguinal hernia due to carcinoma is reported.
2. Evaluating hernias, careful palpation of the sac contents should be made, especially in association with existing anemia.
3. No similar case was found in the English literature.

Acknowledgment

We thank Dr. Alfredo J. Garcia for translation of the paper entitled, "Ciego Tumoral Contenido En Una Hernia Inguinal Estrangulada," Hospital Argent. Dec. 30, 1932. 3:619-22.

A list of references may be obtained by writing The Journal.

Special Article

Alcohol Consumption and the Students' Use Of Hallucinogenic Drugs

Ram N. Singh, Ph. D., and Loretta E. Haddy

In recent years, social scientists have explored the association between sociocultural factors and the use and abuse of drugs (Clausen, 1957: 38-39; Ludwig and Levine, 1965: 106-107; Louria, 1967: 114-115; Salisbury and Fertig, 1968: 83-86; Goode, 1969: 54; Zinberg and Well, 1970: 120; Kimes and Maher, 1971: 3-5; and Baden, 1971: 42-43).

Salisbury and Fertig listed the following reasons for drug use among teenagers: (1) curiosity drive; (2) sexual stimulation; (3) their feelings that their parents' use of alcohol is more irresponsible and dangerous than their own use of marijuana and LSD; and, (4) drugs are fun and their parents are pursuing fun with alcohol.

Kimes and Maher (1971:4) studied the relation between attitudes, knowledge and experience of high school students and their use of alcohol and drugs. The students were asked to indicate the most important factors influencing their decisions regarding the use or non-use of the drugs. Seventeen per cent of the students named their parents as constituting the greatest influence, and 17 per cent said newspapers and magazines filled this role. Thirteen per cent credited friends with this distinction. Still another 13 per cent said that movies had the greatest bearing in shaping their attitudes on drug usage. Furthermore, the students were asked to identify the reasons underlying drug usage. Thirty-nine per cent of the males and 38 per cent of the females mentioned curiosity or "experimentation" (Kimes and Maher, 1971: 5). Thirty-one per cent of the males and 29 per cent of the females suggested "going along with the group" as the motive behind most teen-age involvement with drugs. Thirteen per cent of all students expressed the belief that the most important reason for drug use was the existence of "personal problems."

These investigations suggest that parents and peers have a significant influence on the decision of youths regarding the use of drugs. Researchers, however, have not explored the relation between teen-agers' use of drugs and: (1) their use of alcohol, (2) alcohol consumption of their parents, and (3) influence of peers who are drug users. This study, therefore, was an attempt to relate students' and parents' drinking patterns, peers' use of drugs and the students' use of hallucinogenic drugs. More specifically, the following hypotheses were tested in the present investigation:

H_1: There is no relation between students' drinking pattern and their use of hallucinogenic drugs.

H_2: There is no relation between parents' drinking pattern and students' use of hallucinogenic drugs.

H_3: There is no relation between peers' use of marijuana and LSD and students' use of hallucinogenic drugs.

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Data and Procedures

The area of investigation chosen is Charleston, West Virginia, the county seat of Kanawha County and the capital of the State. Charleston, with approximately 85,000 people, is a metropolitan city depicting urban life on a small scale. The abuse of drugs by high school students has been increasing in Charleston as in other urban cities across the country.

Data were obtained from three high schools in Charleston. The first school chosen in the study was George Washington High School, which is well representative of students of predominantly upper-middle and upper socioeconomic groups.

The second was Stonewall Jackson High School, geographically located in the west section of Charleston. Stonewall Jackson is representative of students from typical middle class families. The third school used for the present investigation was Carver Career and Technical Education Center. The majority of students at Carver come from low income families. The total population of the students was 2,900, but 905 of these were discarded in lieu of incomplete questionnaires. Of the remaining 1,995, 245 were users of marijuana and LSD and 1,750 were non-users. The respondents were white males and females from the 10th, 11th, and 12th grades.

Drug use, the dependent variable, was measured in terms of the students' use of marijuana and LSD. The independent variables in the present investigation were: (1) students' drinking pattern; (2) parents' drinking pattern, and (3) peers' use of marijuana and LSD. The first independent variable, students' drinking pattern, was determined on the basis of two questions. They were asked to indicate whether or not they drink alcohol and how often. The respondents were classified into three groups: (1) Light: those who do not drink and those who drink only occasionally; (2) Moderate: those who drink at parties and on week-ends, and (3) Heavy: those who drink on weekdays and also those who drink everyday.

Parents' drinking pattern was measured in terms of father's and mother's consumption of alcohol. Fathers' and mothers' drinking patterns were categorized as: (1) Light: those who do not drink and light drinkers; (2) Moderate: those who are moderate drinkers, and (3) Heavy: those who are heavy drinkers and active alcoholics. The last independent variable, peers' use of marijuana and LSD, was measured on the basis of two questions: (1) "How many of your best friends, or members of your personal clique of friends, have ever tried marijuana"? and (2) "How many of your best friends, or members of your personal clique of friends have ever tried LSD?" The respondents were classified into three categories: (1) Low: no close friends had tried drugs; (2) Medium: number of close friends who had tried drugs ranged from one to five; and, (3) High: number of close friends who tried drugs ranged from six to 10 and more.

The Chi-square test was used to determine the relation between students' drinking patterns, parents' drinking pattern, peers' use of marijuana and LSD and the use of hallucinogenic drugs. The .05 level of significance was used to reject the hypotheses of this study.

Table 1

Relation Between Students' Consumption Of Alcohol And Their Drug Use

Students' Consumption Of Alcohol	Students' Use of Hallucinogenic Drugs			
	Users		Non-Users	
	N	%	N	%
Yes	236	96.3	1268	72.9
No	9	3.7	472	27.1
Total	245	100.0	1740	100.0

$X^2=64.35$, significant at .01 level, with one degree of freedom.

Table 2

Relation Between Students' Drinking Pattern And Their Drug Use

Students' Drinking Pattern	Students' Use Of Hallucinogenic Drugs			
	Users		Non-Users	
	N	%	N	%
Light	90	36.7	1357	78.3
Moderate	140	57.2	342	19.7
Heavy	15	6.1	34	2.0
Total	245	100.0	1733	100.0

$X^2=188.98$, significant at .01 level, with two degrees of freedom.

Table 3

Relation Between Fathers' Drinking Pattern And Students' Use Of Drugs

Fathers' Drinking Pattern	Students' Use Of Hallucinogenic Drugs			
	Users		Non-Users	
	N	%	N	%
Light	57	24.1	602	36.6
Moderate	145	61.2	904	54.9
Heavy	35	14.7	141	8.5
Total	237	100.0	1647	100.0

$X^2=19.54$, significant at .01 level, with two degrees of freedom.

Table 4

Relation Between Mothers' Drinking Pattern And Students' Use Of Drugs

Mothers' Drinking Pattern	Students' Use Of Hallucinogenic Drugs			
	Users		Non-Users	
	N	%	N	%
Light	118	49.6	951	57.9
Moderate	110	46.2	656	39.9
Heavy	10	4.2	36	2.2
Total	238	100.0	1643	100.0

$X^2=7.95$, significant at .05 level, with two degrees of freedom.

Table 5

Relation Between Peers' Use Of Marijuana And Students' Use Of Drugs

Number Of Peers Using Marijuana	Students' Use Of Hallucinogenic Drugs			
	Users		Non-Users	
	N	%	N	%
Low	63	27.6	1507	86.6
Medium	56	24.6	198	11.4
High	109	47.8	35	2.0
Total	228	100.0	1740	100.0

$X^2=692.20$, significant at .01 level, with two degrees of freedom.

Table 6
Relation Between Peers' Use Of LSD And Students' Use Of Drugs

Number Of Peers Using LSD	Students' Use Of Hallucinogenic Drugs			
	Users		Non-Users	
	N	%	N	%
Low	106	45.5	1442	91.3
Medium	94	40.3	103	6.5
High	33	14.2	35	2.2
Total	233	100.0	1580	100.0

X^2=338.18, significant at .01 level, with two degrees of freedom.

Findings

1. Students' Drinking Pattern

Table 1 shows a significant relation between students' consumption of alcohol and their use of drugs. This relation is significant at .01 level with two degrees of freedom. The proportion of alcohol consumption is significantly higher (96.3 per cent) for drug users than for non-users (72.9 per cent). The students' drinking pattern is also significantly associated with use of hallucinogenic drugs at .01 level (Table 2). It is evident from Table 2 that the majority of the users are moderate and heavy drinkers (63.3 per cent), whereas the proportion of moderate and heavy drinkers is very low in non-users category (21.7 per cent). The hypothesis indicating no relation between students' drinking pattern and the use of hallucinogenic drugs is rejected.

2. Parents Drinking Pattern

The relation between fathers' drinking pattern and students' use of hallucinogenic drugs is significant at .01 level with two degrees of freedom (Table 3). The mothers' drinking pattern is also significantly associated with the use of hallucinogenic drugs at .05 level (Table 4). The difference, however, is more marked in fathers' drinking pattern than mothers' drinking pattern. The proportion of drug users' parents who are moderate and heavy drinkers is higher than the proportion of non-users' parents. The data from these tables allow us to conclude that students' drug use is significantly associated with their parents' drinking patterns. Thus, hypothesis two is rejected.

3. Peers' Use of Marijuana and LSD

Table 5 reveals a significant association between peers' use of marijuana and the students' use of hallucinogenic drugs. This relation is significant at .01 level with two degrees of freedom. The proportion of users' peers who use marijuana and LSD is higher than those of non-users. The relation between peers' use of LSD and the students' use of hallucinogenic drugs also is significant at .01 level with two degrees of freedom (Table 6). It is clear from these tables that students' use of hallucinogenic drugs is positively related to the number of their friends who use marijuana and LSD. Thus, hypothesis three is rejected.

Conclusions

It can be concluded that students' drinking patterns, parents' drinking patterns and the number of peers using marijuana and LSD have significant effects on teen-agers' use of hallucinogenic drugs. Furthermore, this investigation also related students' drinking patterns, parents' drinking patterns, and peers' use of marijuana and LSD to the frequencies of hallucinogenic drugs. The data, however, are not presented because of small cell frequencies and inconsistent patterns. The researchers feel that certain control variables must be included in determining relation between alcohol consumption and the use of hallucinogenic drugs.

A list of references may be obtained by writing The Journal.

Skin for Burn Patients

JAPANESE researchers have developed a "skin" that they feel will shorten tissue repair of burns and skin wounds by preventing dehydration and infection, according to the National Society for Medical Research. Scientists at Tokyo University and Nippon Hikaku Kaisha (Japan Leather Company) say their skin material is immune to rejection. It is made by breaking down bovine collagen—a substance found in connective tissue, bone and cartilege—with various enzymes. The material is then rearranged chemically to make it unreactive.

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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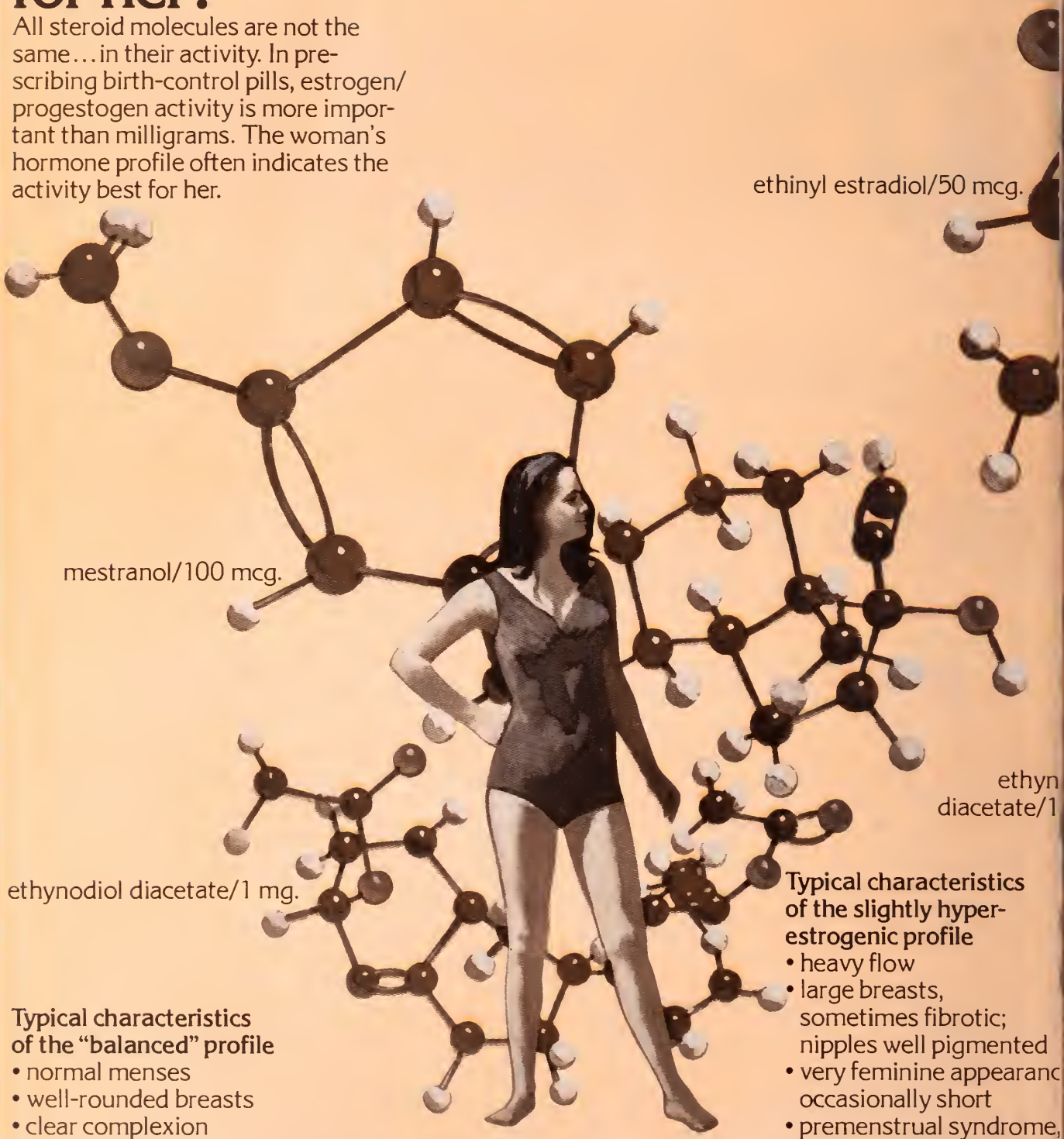

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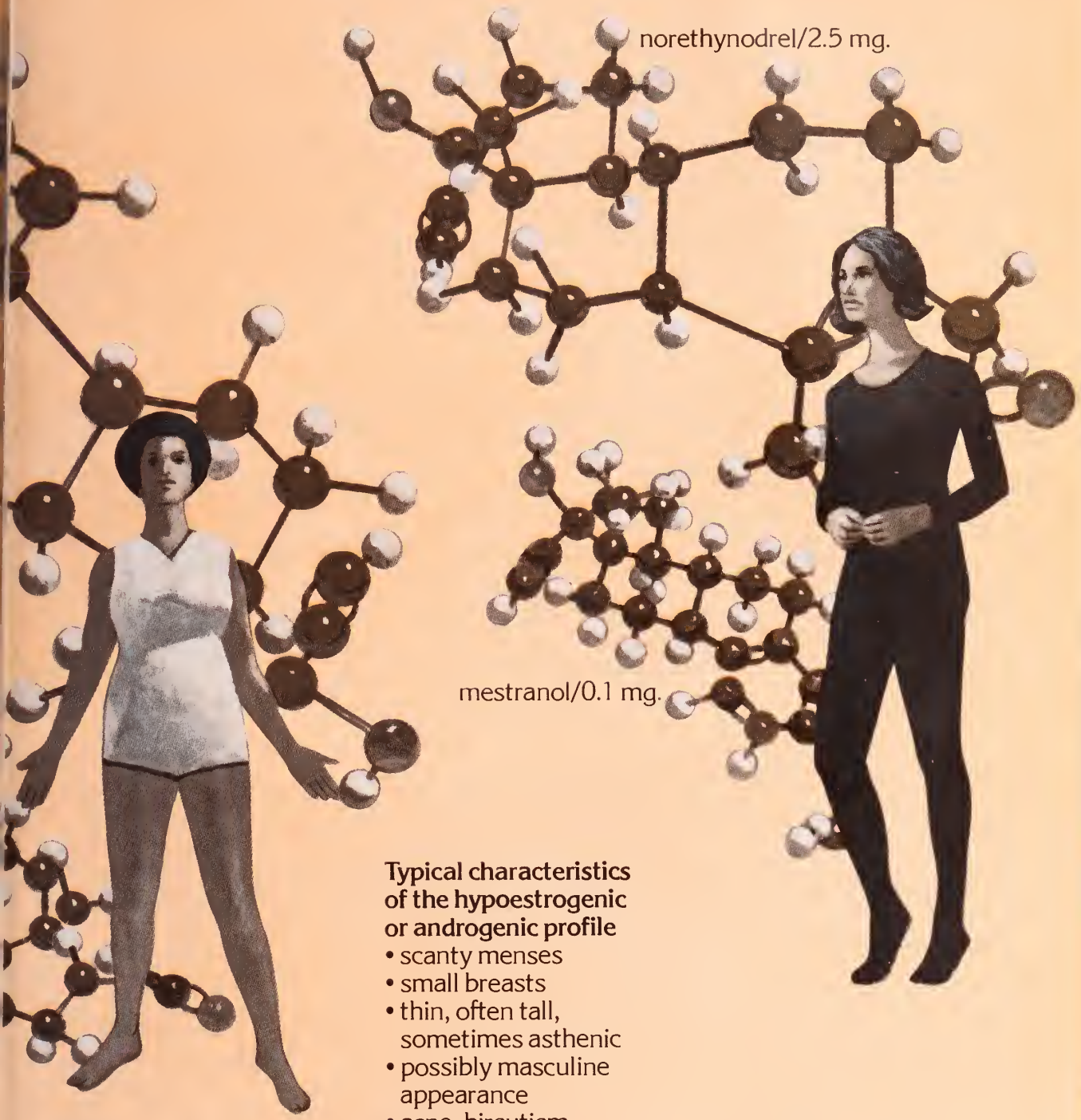

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Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovar adrenal, hepatic or uterine function awaits further study. A decreas glucose tolerance has been observed in a significant percentage patients on oral contraceptives. The mechanism of this decreas obscure. For this reason, diabetic patients should be carefully obser while receiving Ovulen or Demulen therapy. The age of the patient c stitutes no absolute limiting factor, although treatment with Ovulen Demulen may mask the onset of the climacteric. The pathologist sho be advised of Ovulen or Demulen therapy when relevant specim are submitted. Susceptible women may experience an increase blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral c traceptives—A statistically significant association has been dem strated between use of oral contraceptives and the following seric adverse reactions: thrombophlebitis, pulmonary embolism and ce bral thrombosis.

Although available evidence is suggestive of an association, suc relationship has been neither confirmed nor refuted for the follow serious adverse reactions: neuro-ocular lesions, e.g., retinal thro bosis and optic neuritis.

The following adverse reactions are known to occur in patie receiving oral contraceptives: nausea, vomiting, gastrointestinal sym toms (such as abdominal cramps and bloating), breakthrough bleedi spotting, change in menstrual flow, amenorrhea during and after tre ment, edema, chloasma or melasma, breast changes (tenderne enlargement and secretion), change in weight (increase or decreas changes in cervical erosion and cervical secretions, suppression lactation when given immediately post partum, cholestatic jaundi migraine, rash (allergic), rise in blood pressure in susceptible individu and mental depression.

Although the following adverse reactions have been reported users of oral contraceptives, an association has been neither co firmed nor refuted: anovulation post treatment, premenstrual-li syndrome, changes in libido, changes in appetite, cystitis-like syndrom headache, nervousness, dizziness, fatigue, backache, hirsutism, loss scalp hair, erythema multiforme, erythema nodosum, hemorrhag eruption and itching.

The following laboratory results may be altered by the use of or contraceptives: hepatic function: increased sulfobromophthalein rete tion and other tests; coagulation tests: increase in prothrombin, Facto VII, VIII, IX and X; thyroid function: increase in PBI and butanol extrac able protein bound iodine, and decrease in T^3 uptake values; metyrapon test and pregnanediol determination.

References: **1.** Royal College of General Practitioners: Oral Co traception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:26 279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation c Deaths from Pulmonary, Coronary, and Cerebral Thrombosis an Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-19 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relatio Between Use of Oral Contraceptives and Thromboembolic Disease. Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwel P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromb embolism and Oral Contraceptives: An Epidemiologic Case-Contr Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* an *Adverse Reactions* listed above for Ovulen and Demulen are applicabl to Enovid-E and should be observed when prescribing Enovid-E.

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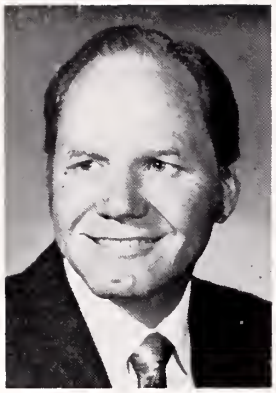

A message from . . .

The President

SEE THE STORK TORMENTING THE ELEPHANT

THE stork is an awkward long-legged bird with strong wings and a weak voice. It often nests on roofs and chimneys of the houses of man. It is a respected and protected bird that is thought to bring good luck. Much folklore has grown up about the stork. The legend that the stork brings babies arises from its loving care of its young.

On the other hand the massive elephant is the acknowledged king of the jungle who has no natural enemies. The elephant spends most of his time foraging for food. His grazing area cannot be mistaken since the trees are devastated. You may not see an elephant in the jungle but you can usually hear the rumbling of his ever active digestive tract. The elephant's trunk is as nimble as a hand that is forever reaching, tearing, conveying and delivering to its greedy mouth.

Somehow I feel that the stork is symbolic of the medical profession. The doctor is generally respected and many people would like to have a doctor nearby. Much folklore has also evolved about doctors who are also thought to bring babies. But the doctor as we know him may need protection to prevent his extinction.

The elephant may be compared to the federal government with its numerous agencies including HEW. Government is continuously seeking more revenue to dissipate in deficit spending. Devastation in the name of progress can be seen and heard throughout the land. Nothing escapes the active probings of its agencies.

Like the elephant, federal agencies implementing the legislation of the Congress have no natural enemies. The stork is a poor fighter.

(P.S. I'm indebted to my wife, Bertha, for the art work.)

Worthy W. McKinney M.D.

W. W. McKINNEY, M. D., *President*

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EDITORIALS

NURSES AND DOCTORS

There are a fair number of doctors around who still remember the days when nurses would stand up when a doctor entered a hospital nursing station. There are probably few who regret the passing of those days. Not that it wasn't nice, and flattering too. But there was always that vague, self-conscious feeling of uneasiness associated with it, and it was such a waste of time.

In this regard, things have changed in medicine now and the changes all predated the clamorous prodding of women's lib agitation. Maybe the doctors needed the flattery in those days. Maybe they needed it to compensate for feelings of inadequacy which stemmed from an awareness of their lack of effective tools and knowledge to cure many of the diseases they daily encountered. And the nurses in their helpless frustration over the impotence of their own healing powers needed the fantasy of an all powerful, all wise, all healing *Doctor* to reassure themselves.

Doctors now need not demand, nor do nurses need to give, this obeisance. This is some indication that both face their duties with a different, more assured attitude of confidence and competence. Both professions have raised their level of therapeutic endeavors and both now need one another in ways that were formerly unlikely even to be dreamed.

Recognition of this new spirit of mutual confidence and respect between doctors and nurses is reflected in the work of the Liaison Committee between Doctors and Nurses, both at the national and state level. In a joint position statement of the Association's Nurses Liaison Committee and the West Virginia Nurses Association endorsed by the Council of the West Virginia State Medical Association last fall four principles are enunciated (See page 102).

Principle No. 1 states: *Delivery of health care is by its nature a team operation that incorporates the two primary health care professions (medicine and nursing) and various other health care disciplines.* This implicitly recognizes that the professional nurse should share responsibility with the physician especially in regard to the management of the patient.

Principle No. 2 states: *The West Virginia State Medical Association and the West Virginia Nurses Association recognize the need for and will collaborate to facilitate the expansion of the role of the nurse in providing health care for the patient.* This recognizes the potential of and encourages growth in the scope of nursing practice. It also recognizes the historic dependence of physicians on nurses.

Principle No. 3 states: *The West Virginia State Medical Association and the West Virginia Nurses Association encourage and support various levels of education for professional and practical nursing and emphasize continuing education for all nurses.* In this, both professions pledge collaboration in developing resources

and opportunities for professional advancement through education. The principle also recognizes an expanding role for the practical nurse.

Principle No. 4 states: *Patient care will be better served if nurses are extensively involved in the delivery and planning of health care.* In this, the two professions recognize and decry the growing disinvolvement of professional nurses with direct patient care because of preoccupation with administrative details. It also encourages active participation of nurses on health care planning committees in communities and within health care institutions.

This joint statement simply expresses the way things now are between doctors and nurses. It is a great improvement. These two great professions form the bedrock of our health care system.

A swirl of political proposals concerning the future of our health care system throws into doubt the manner in which health care will be financed in the future. No legislation, however, will alter the fundamental manner in which the individual patient will be ministered to nor the fundamental and ever growing closeness between doctors and nurses.

HEROIN PENETRATION OF BLOOD-BRAIN BARRIER

Heroin addiction has become a grave problem in the United States. According to the United States Justice Department the number of heroin addicts in the United States has multiplied 12 times in the last 10 years, from 50,000 to 600,000. The average layman does not understand how easily addiction to heroin may be acquired, or its dreadful consequences, or how difficult it is to overcome the addiction. Individuals truly addicted to heroin will steal or, if necessary, commit murder to procure funds to purchase this dangerous drug. The seriousness of this problem, however, is not the theme of this essay, but rather some new facts concerning the rapidity of its absorption into the brain tissue. Any information which offers new facts concerning absorption of heroin, or its mode of action, or throws any light on its pharmacological action is of distinct value.

Recently some interesting work by Oldendorf et al[1] has been reported on the passage of heroin, as well as some other drugs, through the blood-brain barrier. It is known that the blood-brain barrier is a most important factor in determining the amount of a drug that reaches the extracellular fluid of the brain after systemic administration. The blood-brain barrier which separates the blood from the parenchyma of the central nervous system including the cerbro-spinal fluid consists of the walls of the blcod vessels of the central nervous system and the surrounding glial membranes. Presumably its function is to guard the brain from the absorption of certain substances.

It is not in the province of this essay to describe in detail the careful methods used by Oldendorf and his co-workers in their experiments. Suffice it to say that labeled heroin (and labeled morphine, codeine and methadone) were used in this study. These agents were injected into the common carotid artery of pentobarbitalized rats which were decapitated 15 seconds later. The amount of the agent absorbed in the brain was then calculated.

It was observed that under the conditions of the experiment the uptake of morphine was immeasurable, the uptake of codeine was 26 per cent, that of heroin 68 per cent, and that of methadone 42 per cent. The noteworthy finding was the high percentage of heroin absorption compared to the other substances studied. After heroin is absorbed it is rapidly hydrolyzed to 6-monoacetylmorphine and morphine. The morphine released remains in the brain for a relatively long period, partly because it is retarded in its reabsorption by the blood-brain barrier. Oldendorf et al believe that this may, in part, account for the greater pharmacological affectiveness of heroin. These authors point out also that the high uptake of heroin suggests that entrance of this substance into the brain tissue occurs 10 to 20 seconds after intravenous injection. They suggest further that the rapid entry relative to morphine may be a factor in the more intractable addiction to heroin.

These scientific facts help explain the seriousness of heroin addiction but in no way do they solve the problem. The best solution is, of course, to make an heroic effort to prevent the occurrence of heroin addiction, especially among young individuals.

---

1. W.H. Oldendorf et al. Science 78: 984 (Dec.) 1972

TREATMENT OF BELL'S PALSY

(*Editor's Note: The following editorial was published in the December 21, 1972, issue of The New England Journal of Medicine and we are grateful to both The Journal and the author for granting permission to reprint it in its entirety in our Journal for the benefit and enlightenment of our readers*).

Facial paralysis of abrupt onset is common. Few cases are associated with otic infection, and

there is debate about possibly causal relations with diabetes, hypertension and pregnancy. Almost all cases are idiopathic (Bell's palsy).

One theory ascribes the initial insult to unstable blood vessels, susceptible to excessive vasoconstriction on exposure to cold or other stimuli. Ischemia leads to swelling and compression of the nerve within its bony canal, thus aggravating the ischemia. But the relation to cold is uncertain; there is doubt about liability to compression since the nerve occupies less than 50 per cent of the canal; the postulated vascular instability embraces the supernatural; and the theory does not explain why paralysis is unilateral.

The alternative theory is based upon infection, also with meager evidence. Vesicles of herpes zoster may be seen, or there may be antibody evidence of zosterian infection. Experimentally, intraneural injection of herpes-simplex virus causes facial paralysis in rabbits. In Israel, cases of Bell's palsy appeared in clusters or "epidemics," but this was not true in Minnesota.[1] Bilateral facial paralysis in the Guillain-Barré syndrome and other evidence implicate immune mechanisms in Bell's palsy.

Untreated, almost all patients with Bell's palsy recover to some extent, but some are left with disfiguring facial asymmetry due to weakness or contracture, and there may be awkward "synkinetic" movements or excessive lacrimation. Treatment could be assessed if patients destined to suffer permanent complications could be identified. Clinical criteria have limited value. When the palsy is only partial one week after onset, almost all patients recover completely, but this proportion accounts for about 40 per cent. Most have complete paralysis; some of these also recover fully, some partially, and some not at all. Whether pain, loss of taste, or disorders of lacrimation imply poor prognosis is debated.

Other tests are used to determine prognosis. The most reliable seems to be nerve excitability, introduced in 1872 by Duchenne. When excitability is retained ("conduction block"), 90 per cent of the patients recover completely. When excitability is absent ("denervation"), only 20 per cent recover completely. When excitability is impaired but not absent, about ½ recover completely.[2] Occasionally, clinical function may ultimately be good although the nerve remains inexcitable.

Even when recovery is incomplete, the cosmetic result may be acceptable. In the Mayo series,[1] only one of 121 untreated patients considered the result unsatisfactory. In another study, about 10 per cent of all patients were dissatisfied with the final result.[3] Again, 16 of 22 patients with complete denervation and all of 39 patients with partial denervation were satisfied.[4] Therefore, it is not possible to assess therapy only in terms of complete recovery, which varies from 28 to 80 per cent in different series, perhaps because of varying criteria. Treatment is directed to the few who do not achieve satisfactory results, probably no more than 10 per cent of all patients.

A few years ago, Bell's palsy was regarded as "a surgical emergency" since decompression of the nerve seemed a rational treatment. Controlled studies, however, cast doubt on the efficacy of surgical intervention.[5, 6] Cortisone was used by Taverner in 1954 with inconclusive results. He favored ACTH therapy in a 1967 trial that lost statistical significance when the originally controlled conditions were abandoned. In 1971,[7] he found prednisolone more effective; in 32 of 94 patients treated with ACTH some degree of denervation developed, and six showed less than 50 per cent recovery, whereas only 13 of 92 patients treated with prednisolone recovered incompletely and none were left with less than 50 per cent recovery.

In this issue of the *Journal*, the authors (Adour et al: Prednisone Treatment for Idiopathic Facial Paralysis (Bell's Palsy. *NEJM* 1268-1271, 1972) describe an evaluation of prednisone. Because treatment seemed so effective in relieving pain, the original plan for a double-blind trial was abandoned; untreated patients seen before 1970 were compared with treated patients after 1970. Eighty-eight per cent of treated patients recovered full facial motion, as compared to 64 per cent of untreated patients; 10 per cent of the untreated group and none of the treated patients were left with denervation although, inexplicably, there was no statistically significant difference in the numbers left with partial denervation. Subjective assessment of outcome was not reported.

Prednisone or prednisolone therapy may now become routine treatment for Bell's palsy. But we still do not know the cause, or precisely how steroids act, and the treatment is not uniformly effective. A diehard skeptic might be concerned that the treated and untreated patients of Adour et al. were seen in different years. An infectious cause of Bell's palsy might vary in virulence, and this therapeutic trial might be invalid. Moreover, although complications of therapy were few (4 per cent), they were not inconsequential. The cumulative effect of published reports, however, may now make it difficult to withhold treatment in future controlled trials.—*Lewis P. Rowland, M. D., Professor and Chairman, De-*

partment of Neurology, Hospital of the University of Pennsylvania, Philadelphia.

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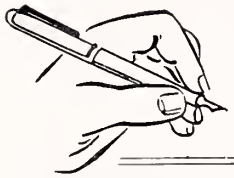


Our Readers Speak

WEST VIRGINIA AND THE DILEMMA OF THE FOREIGN MEDICAL GRADUATE

There are many foreign medical graduates (FMG) in the State of West Virginia who are practicing only under a temporary license. This has been magnified recently in the news media.

These foreign graduates came here not because they love the mountains or the "almost heaven, West Virginia" but because West Virginia is one of the few states which issue licenses under a temporary basis pending permanent licensure. Some like the relative peacefulness and simple life and elect to stay; many go to other more populous cities and states as soon as they earn their FLEX State Board examinations and qualify, since there is likely to be more lucrative and educationally stimulating practice opportunities elsewhere.

West Virginia has been a haven to these foreign MDs—under temporary license the foreign MD could practice as "real doctors" and earn at least commensurate compensation, in contrast to just working as perennial house physicians, or jump from one super-specialty to another in the big cities. On the other side of the coin, the FMG has provided much needed medical care in areas which are in dire need of doctors. So the benefits have been bilateral.

From the recent lay publications, a shadow has been cast on the label: "Foreign Medical Graduate" —with some connotation that the majority are not licensed and, therefore, not qualified legal doctors. True. But many of these doctors are not professionally unqualified.

In order for a foreign medical graduate to even undergo accredited training in the U. S. A. he has to pass the E.C.F.M.G. examination. His papers are screened and scrutinized by the Educational Council for Foreign Medical Graduates who also pass judgment on whether his medical school is acceptable or not. Those who insist on coming here without the ECFMG certificate either work as technicians, I.V. therapists or mental state institution personnel.

Upon graduation from their own medical schools the FMG can either elect to go "abroad" soon enough, and while everything is still fresh in mind, the ECFMG examination is hurdled without much difficulty. Some have to stay at home, practice for many years, or even narrow to a specialty (not accredited) in their home institutions. Many of these are casualties in the ECFMG examinations and the review for the examinations is really an uphill climb. Those who make it undergo anywhere from two years to half a decade of stateside training all over again. Those who don't and insist on staying here work as technicians and keep trying at the ECFMG examinations, which seem to get harder as one grows older.

The main dilemma is that after the FMG has qualified in his specialty training he has no place to go, because he is not yet allowed to take the State licensure examinations in many states. He can elect to stay in the big cities and work as house physician (not a real practicing doctor yet), or bone up his training by going into more "sub-specialization or super-specialization." Many of these doctors go to West Virginia because of the temporary license provision. Up until recently.

These are some of the doctors who have come to be in the limelight recently as being unqualified because they are unlicensed. Many are unlicensed because by law they could not be allowed to take the State Board Licensure examination—they have to have that little magic "green card" issued by the U. S. Immigration and Naturalization service which signifies one has a permanent visa. On the average it takes about four years for the immigration papers to be issued after a petition for visa is submitted or approved after which time the FMG could start reviewing again to take the State Board Licensure examination. It takes another five years after one is an immigrant to be qualified to apply for U. S. citizenship.

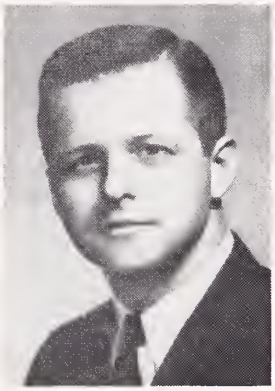
It seems, however, the laws are changing and even the haven of West Virginia would repel FMGs from establishing here. The bilateral benefits to both parties are thereby not availed of. If West Virginia were to compete with other states for attracting doctors to care for its population it is already at a disadvantage. Possibly the doctor shortage would be aggravated.—*Samuel M. Santibanez, M.D., Attending Surgeon, Grafton City Hospital, Grafton, West Virginia; and President, Tygart's Valley Medical Society.*

GENERAL NEWS

Two Additional Speakers Selected For 106th Annual Meeting

The Program Committee has announced that two prominent physicians have been added to the list of guest speakers for the 106th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22-25.

Theodore M. King, M. D.



C. Richard Conti, M. D.

Dr. A. Thomas McCoy of Charleston, Chairman of the Program Committee, announced that Drs. Theodore M. King and C. Richard Conti of Baltimore will present papers during the meeting.

Doctor King will present a paper on "Abortifacients—Efficacy and Untoward Effects" at the second general scientific session on Friday morning, August 24.

Doctor Conti will participate in a "Symposium on New Concepts in the Medical and Surgical Treatment of Coronary Artery Disease" at the first general scientific session on Thursday morning, August 23. His subject will be "Medical Therapy of Angina Pectoris."

Theodore M. King, M. D.

Dr. Theodore M. King, Professor and Director of the Department of Gynecology and Obstetrics at Johns Hopkins University School of Medicine, is a native of Quincy, Illinois. He was graduated from Quincy College, received a Master's Degree in zoology from the University of Illinois, and a Ph. D. Degree in physiology from Michigan State University. He received his M. D. Degree in 1959 from the University of Illinois School of Medicine.

He interned at the Presbyterian-Columbia Medical Center in New York City and served a residency at the Sloan Hospital for Women in New York City. He served as a member of the faculty at the University of Missouri School of Medicine, 1965-68, and was Professor and Chairman of the Department of Obstetrics and Gynecology at the Albany Medical College of Union University in Albany, New York, 1968-71. He was named to his present position in November, 1971.

He was certified by the American Board of Obstetrics and Gynecology in 1967 and is a member of the American College of Surgery and the American College of Obstetricians and Gynecologists. He also is a member of the Association of Professors of Gynecology and Obstetrics and is Gynecologist-Obstetrician-in-Chief at the Johns Hopkins Hospital in Baltimore.

C. Richard Conti, M. D.

Dr. C. Richard Conti, a native of Allentown, Pennsylvania, is Associate Professor of Medicine at the Johns Hopkins University School of Medicine and serves as Medical Director of the Cardiovascular Diagnostic Laboratory and Wellcome Research Laboratory at that institution.

He was graduated magna cum laude from Lehigh University and received his M. D. Degree in 1960 from the Johns Hopkins University School of Medicine. He interned and served a residency at the Johns Hopkins Hospital and was Chief Resident of the Osler Medical Service at that Hospital, 1967-68. He has been a member of the faculty at Johns Hopkins since 1968 and also serves as Visiting Physician at Good Samaritan Hospital and Baltimore City Hospitals.

He served as a Captain in the Medical Corps of the United States Air Force, 1962-64, and was certified by the American Board of Internal Medicine in 1967. He also is a member of the Subspecialty Board on Cardiovascular Disease and a member of Phi Beta Kappa, Alpha Omega Alpha, American College of Physicians and the American College of Cardiology.

Scientific Program Nearly Completed

Doctor McCoy announced that arrangements have nearly been completed for the scientific program which will be presented during the meeting. The other members of the Program Committee are Drs. William H. Carter of Charleston, C. Richard Daniel of Beckley, Robert G. Janes of Fairmont and Philip M. Sprinkle and J. Hugh Wiley of Morgantown.

It was announced previously that Dr. Russell B. Roth of Erie, Pennsylvania, President Elect of the American Medical Association, will deliver an address before the first session of the House of Delegates on Wednesday afternoon, August 22. Doctor Roth will be installed as President of the AMA at the Annual Convention in New York City in June.

Other speakers who have accepted invitations to present papers at the scientific sessions include Dr. John A. Kirkpatrick, Professor of Radiology and Professor of Pediatrics at the Temple University School of Medicine, and Dr. James J. Morris, Jr., Associate Professor of Medicine and Project Director of the Myocardial Infarction Research Unit at the Duke University Medical Center in Durham, North Carolina.

Doctor Kirkpatrick will present a paper at the second general scientific session on Friday morning and Doctor Morris will present a paper on Angiographic and Hemodynamic Aspects of Coronary Artery Disease" during a symposium at the first scientific session on Thursday morning.

Business Sessions

The Pre-Convention Meeting of the Council will be held on Wednesday morning, August 22, and the first session of the House of Delegates is scheduled to be held that afternoon. The final session of the House of Delegates will be held on Saturday afternoon, August 25.

Additional details concerning the 106th Annual Meeting at The Greenbrier will be announced in future issues of *The Journal.*

Educational Meeting of Wheeling Clinic April 11 At Oglebay

The Wheeling Clinic Quarterly Educational Meeting will be held on April 11 at Wilson Lodge at Oglebay Park in Wheeling.

The principal speaker will be Dr. Eugene Schrae LaPlante, whose subject will be "Current Status of Renal Transplantation." Doctor LaPlante is Assistant Professor in the Department of Surgery at the West Virginia University Medical Center.

Dr. Rizal V. Pangilinan, Chairman of the Educational Committee of the Wheeling Clinic, also announced that the Clinic plans to participate in the Student American Medical Association MECO Program.

Other meetings scheduled for the year were announced. A seminar by the Department of Medicine will be held on June 13 with Dr. Albert Valentine in charge. On September 12, the Department of Obstetrics and Gynecology will hold a seminar with Dr. A. Athari in charge. Doctor Pangilinan will direct a seminar on Diabetic Retinopathy on November 14 for the Department of Opthalmology.

Cardiac Workshop At UK

"Cardiac Diagnosis and Treatment" will be the subject of a two-day workshop offered by the College of Medicine of the University of Kentucky at Lexington April 30 and May 1. The registration fee is $60. For further information, contact Frank R. Lemon, M. D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Members of the Medical Licensing Board of West Virginia and others recently attended a banquet sponsored by the Federation of State Medical Boards of the United States in Chicago at the Palmer House. Dr. Carl A. Hoffman of Huntington, President of the American Medical Association, delivered the annual Walter L. Bierring Lecture at the banquet. Shown above are, from bottom left, clockwise, Dr. and Mrs. Harry S. Weeks, Jr., Wheeling; Custer Holliday, Executive Assistant, State Medical Association; Dr. Richard E. Flood, Weirton; Dr. Ross E. Newman, Beckley; Mrs. Greta Pridemore, Supervisor of the state licensing board staff; Dr. N. H. Dyer, State Health Director and Secretary of the licensing board, and Mrs. Dyer; and Dr. and Mrs. Frank J. Holroyd, Princeton. Also attending was Dr. Maynard P. Pride, Morgantown, a member of the state licensing board and also a Director of the Federation of State Medical Boards. The banquet was held in conjunction with the AMA's 69th Annual Congress on Medical Education. The FSMB was one of four other sponsoring groups.

Final Program Announced For OB-GYN Workshop

The final program has been announced for the Second Annual Clinical Workshop in Obstetrics and Gynecology which will be held in Charleston at the Charleston House, May 4-5.

Sponsors of the program are the West Virginia Obstetrical and Gynecological Society, the West Virginia Section, American College of Obstetrics and Gynecology; and the West Virginia Section, Nurses Association, ACOG.

The combined program for physicians and nurses will open with a Hospitality Evening on Friday, May 4, from 8 to 11 P. M. at the Charleston House.

Participants in the combined physicians and nurses session Saturday morning will be welcomed by John J. Battaglino, M.D., President of the West Virginia Obstetrical and Gynecological Society.

Speakers and their topics will include:

"Cystic Fibrosis in Pregnancy"—Stephen Feaster, M. D., Resident, Obstetrics and Gynecology, West Virginia University Medical Center;

"Amniotic Fluid Analysis"—Richard Manning, M. D., Resident, Ohio Valley Hospital, Wheeling;

"Assessment of Fetal Maturity"—James A. O'Leary, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Loyola University Medical Center, Maywood, Illinois;

"Genetic Indications for Prenatal Diagnosis"—Havelock Thompson, M. D., Associate Professor of Pediatrics, WVU Medical Center;

"Case Report—Unexpected Trophoblastic Disease Found at the Time of Cesarean Section"—T. Keith Edwards, M. D., Bluefield Sanitarium, Bluefield;

"Trophoblastic Disease"—T. J. Ma'luf, M. D., Beckley.

Luncheon Roundtables

Physicians and nurses will participate in luncheon roundtable discussions. The topics and table leaders will be:

"Intrauterine Evaluation of the Fetus"—Doctor O'Leary; "Clinical Applications of Genetics in the Practice of Obstetrics and Gynecology and Neonatal Pediatrics"—Doctor Thompson; "Diseases of the Vulva"—Lester A. Wilson, Jr., M. D., Professor of Obstetrics and Gynecology, University of Virginia; "Carcinoma of the Cervix: Detection and Management"—Walter A. Bonney, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, WVU Medical Center;

"The Nurse Midwife"—Carole Kaufman, Associate Professor of Nursing, Columbia University School of Nursing; "The LaLeche League"—Nancy Tolliver, R. N., LaLeche League, Charleston; "Laparoscopy: Uses and Complications"—Robert P. Pulliam, M. D., Beckley, Program Co-Chairman; "Immediate Evaluation of the Newborn"—Herbert H. Pomerance, M. D., Director of Pediatrics, Charleston Area Medical Center; "The Intrauterine Device"—Charles W. Merritt, M. D., Beckley.

Saturday Afternoon

Speakers and their topics at the Physicians' Session Saturday afternoon will be:

"Medical Humor—Family Life"—A. J. Villani, M. D., Welch; "Exploratory Laparotomy as Routine Pre-Treatment Investigation in Carcinoma of Cervix"—Doctor Bonney; "Effect of Diethylstilbestrol on Female Fetus"—Larry Curnutte, M. D., Charleston; "Carcinoma of the Vulva Arising in Condylomata: An Interesting Case Report"—Joseph W. Plautz, M. D., Golden Clinic and Memorial General Hospital, Elkins (Temporary: Methodist Hospital, Indianapolis, Indiana); "Mixed Mesodermal Sarcoma"—Doctor Wilson;

"Cesarean Section Hysterectomy"—Doctor O'Leary; "Metastatic Adenocarcinoma to the Cervix Uteri from Extragenital Source"—Robert Nerhood, M. D., Department of Obstetrics and Gynecology, WVU Medical Center; "Laparoscopy: Uses and Complications"—Doctor Pulliam; "Evaluation of Dalkon Shield in Private Practice"—Doctor Merritt.

A business meeting of the West Virginia Obstetrical and Gynecological Society will be held at 5 P. M.

Nurses' Session

The Nurses' Session will be held Saturday afternoon with a welcome by Diane Kopical, R. N., of South Charleston, Secretary-Treasurer of the West Virginia Nurses Section and Program Co-Chairman. The speakers and their topics will include "The Need for Pediatric Clinical Specialists"—Judy Truvant, R. N., Pediatric Clinical Specialist, Charleston Area Medical Center, Memorial Division; "The Nurse Midwife"—Carole Kaufman; "Maternal Role Identity"—Dorothy Henson, R. N., Department of Nursing Instruction, Morris Harvey College, and "New Trends in the Care of the High Risk Newborn"—Doctor Pomerance.

A West Virginia Section meeting will follow from 4:15 to 5:15 P. M.

In addition to the luncheon on Saturday there will be a dinner dance for participants and their spouses that evening.

Mrs. Mary Martha Merritt, legislator from Raleigh County, will direct wives' entertainment Saturday morning. Tentative schedules include a tour of the Governor's Mansion and legislative chambers.

There will be a physician's registration fee of $20 and a nurse's registration fee of $15. Additional information may be obtained by contacting Dr. Robert P. Pulliam, 120 Professional Park, Beckley, W. Va. 25801.

Meeting Date Announced

The 33rd Annual American Medical Association Congress on Occupational Health will be held September 17-18 in Philadelphia at the Benjamin Franklin Hotel. Program information will become available in May.

Special Meeting of the Council In Charleston on March 4

A special meeting of the Council was held at the Holiday Inn No. 1 in Charleston on Sunday, March 4, with the Chairman, Dr. Harry S. Weeks, Jr., of Wheeling, presiding.

Doctor Weeks announced at the outset that the primary purpose of the meeting was to review recommendations made by the Legislative Committee during a meeting held the preceding evening. He called upon Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, to review bills of interest which had been introduced since the regular 60-day session of the 1973 Legislature was convened on February 14.

Smallpox Bill Passed Early in Session

Doctor Holroyd reported the Committee had considered approximately 50 bills of interest to the profession and noted that at least several bills strongly supported by the Association were receiving early attention at the Capitol. He said a bill to repeal the present law requiring mandatory smallpox immunization of school children had passed the House and would be on passage stage in the Senate the following day (Subsequently the bill was passed on March 5 by the Senate and was the first bill to be passed by both the Senate and House during the session with the exception of an emergency bill approved a few days earlier to permit airport authorities to hire security guards to comply with federal skyjacking regulations).

Doctor Holroyd also introduced the following three members of the Legislature present to aid in discussions at the Legislative meeting: Dr. Roy A. Edwards, Jr., of Huntington, Mrs. Charles W. Merritt of Beckley and Mrs. J. A. B. Holt of Charleston. He said Dr. David E. Wallace of Madison, a member of the State Senate, was unable to attend but had passed along pertinent information concerning legislative measures under consideration by the Senate.

Abortion and Other Bills of Interest

It was reported that an abortion bill was being prepared for introduction in the Legislature as a result of a decision of the United States Supreme Court in January in re existing abortion laws throughout the country. Doctor Holroyd said the headquarters staff had complied with requests from both the attorney general's office and interested legislators for information on proposed guidelines suggested by such organizations as the American College of Obstetrics and Gynecology.

The Council voted to request that any proposed abortion bill be forwarded to appropriate officers of the West Virginia Obstetrical and Gynecological Society for study and report back to the Legislative Committee.

The Council also approved a similar recommendation in re a bill being drafted to provide for the licensing of midwives. This legislative matter was introduced early in the session and referred to a sub-committee of the House of Delegates to draft a substitute bill for consideration by the Legislature.

Officials of the West Virginia University Medical Center and the directors of several state agencies were on hand during both the Legislative and Council meetings to discuss their proposed budget requests submitted to the Legislature for the fiscal year, 1973-74.

Doctor Holroyd stated that action on many other health related pieces of legislation were still being considered by both Senate and House committees and that the Association's Legislative Committee and staff were currently reviewing all bills introduced and referred to committees on a daily basis. He said the membership of the Association would be kept informed concerning legislative developments periodically during the remainder of the session.

1973 AMA Medicredit Bill Endorsed

Mr. James S. Imboden of Columbus, Field Representative of the American Medical Association, announced that the new 1973 Medicredit Bill (H. R. 2222), endorsed by the American Medical Association, had been introduced on January 18 in the United States House of Representatives and an identical bill (S. 444) in the United States Senate.

Mr. Imboden stated that the Medicredit Bill was designed by the AMA as a three-pronged approach to providing health insurance protection. He said the proposal would:

(1) Pay the full cost of health insurance for those too poor to buy their own.

(2) Help those who cannot afford a part of their health insurance cost; the less they can afford to pay the more the government would pay.

(3) See to it that no American would have to bankrupt himself because of a catastrophic illness.

Mr. Imboden stated that the bill contains modifications and improvements on the Medicredit Bill which had been introduced in 1971 and considered during the 92nd session of Congress. He pointed out that a total of 174 members of the United States Senate and House of Representatives had cosponsored the Medicredit Bill in the last Congress.

The Council voted unanimously to go on record as approving the 1973 Medicredit Bill as proposed by the American Medical Association.

Election of Honorary Members

The following physicians were elected to honorary membership in the West Virginia State Medical Association:

Name	*Address*	*Society*
S. Elizabeth McFetridge	Shepherdstown	Eastern Panhandle
Halvard Wanger	"	" "
Hubert T. Marshall	Morgantown	Monongalia
L. A. Lyon	Wheeling	Ohio
Earl S. Phillips	"	"

Meeting with Compensation Officials

Dr. Worthy W. McKinney, the President, and Dr. Kenneth G. McDonald, the Treasurer, reported that a number of members of the Association attended a meeting called by officials of the Workmen's Compensation Fund on February 21.

They both reported that the meeting was beneficial to all in attendance as the agenda was limited to discussion of the Fund's current policy in re disability determinations and other problems facing that agency.

The Council meeting was attended by Dr. Harry S. Weeks, Jr., of Wheeling, Chairman; Dr. Worthy W. McKinney of Beckley, President; Dr. A. Thomas McCoy of Charleston, President Elect; Dr. William E. Gilmore of Parkersburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. Maynard P. Pride of Morgantown, Member of the Executive Committee; Drs. Charles E. Andrews, Morgantown; Thomas P. Long of Man; Carl A. Liebig of Keyser; J. D. H. Wilson of Clarksburg; Joseph B. Reed of Buckhannon; F. Lloyd Blair of Parkersburg; Jack Leckie of Huntington; W. Alva Deardorff and George V. Hamrick of Charleston; Richard G. Starr of Beckley; and John J. Mahood of Bluefield; and Mr. William H. Lively, Executive Secretary; and Mr. Custer B. Holliday, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Health Department; Dr. Mildred Mitchell-Bateman of Charleston, Director of the State Mental Health Department; Dr. L. J. Pace of Princeton, Past President; Mr. James S. Imboden of Columbus, AMA Field Representative; and Mrs. J. A. B. Holt of Charleston.

Medical And Chirurgical Faculty Meets In Baltimore April 25-27

The 175th Annual Meeting of the Medical and Chirurgical Faculty of Maryland will be held April 25-27 at the Baltimore Civic Center.

Dr. Russell B. Roth, President-Elect of the American Medical Association, will be the keynote speaker.

General topics in the scientific program will include:

"Problems in Ischemic Heart Disease," "Diseases of the Colon," "Difficult and Current Problems in Treatment of Infectious Diseases," "The Family Practice Approach to Management of Illness in the Academic Medical Setting;"

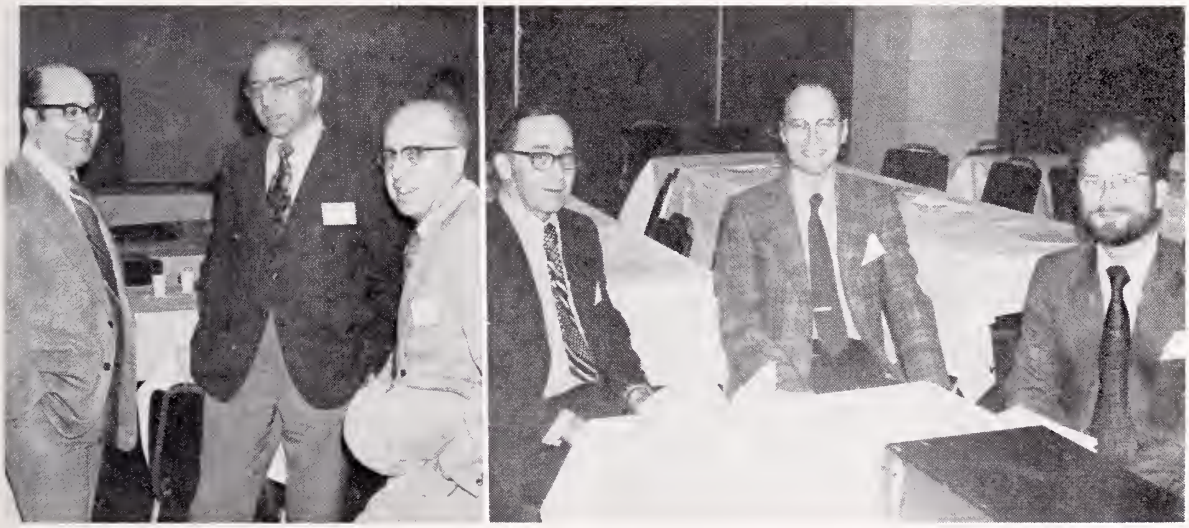
"Recognition and Management of Common Ocular Problems," "Why Treat Diabetes?," "Current Concepts in the Treatment of Cancer," "The Inevitable Review of Physician Performance: How and By Whom?," "Modern Trends in Geriatric Medicine," "Sexuality and the Practice of Medicine;"

"The Problems of Polyarthritis," "Staging and Treatment of Lymphomas of the Skin," "Post-Surgical Respiratory Insufficiency," "Newer Concepts in Plastic Surgery," "Problems of Smell in Medical Practice," "The Chronic Renal Failure Patient: Dialysis and Transplantation;"

"Newborn Emergencies," "The Therapeutics of Congestive Heart Failure," and "Evaluation and Management of Lumbar Discogenic Disease."

There will be no registration fee. The program is acceptable for 13 credit hours by the American Academy of Family Physicians and the AMA Physician's Recognition Award.

For further information contact the Medical and Chirurgical Faculty of the State of Maryland, 1211 Cathedral Street, Baltimore, Maryland 21201.



Among speakers and participants at the recent Mid-Winter Clinical Conference (See March Medical Journal) in Charleston were, in left photo, Dr. George H. Khoury, left, West Virginia University Medical Center, a speaker on heart diseases; Dr. Herbert H. Pomerance of Charleston and Dr. L. M. Eckmann of South Charleston, participants. In the right photo are, from left, Dr. Charles E. Andrews, WVU Medical Center, who presided at the concluding session, and Drs. N. Leroy Lapp and Edwin J. Morgan, WVU Medical Center, who spoke on respiratory diseases in miners.

New York State Pathologists To Hold April Institute

The New York State Society of Pathologists will hold its Fourth Annual Continuing Education Institute, April 27-29, in New York City.

This Institute will be dedicated to the memory of Paul Klemperer, M. D., whose studies in diseases of the mesenchyme provided the morphologic basis for the current advances in Immunopathology.

The first half day will be devoted to the presentation of papers by prominent students of Dr. Klemperer, including a Memorial Lecture.

The Friday Afternoon Session will be a panel presentation on Diagnostic Immunology, chaired by Pierre W. Keitges, M. D., Professor of Pathology, University of Kansas.

A slide seminar on Hematologic Diseases will be conducted on Saturday, by John W. Rebuck, M. D., Professor of Pathology, Wayne State University. Registrants will receive in advance color transparencies and/or smears and sections of peripheral blood and bone marrow, for their study.

The registration fee of $125.00 will provide admission to all sessions, the seminar study slides, transaction of the slide seminar and luncheons on Friday and Saturday.

On Sunday, April 29, there will be a Workshop for Residents, covering the Practice of Pathology. A faculty of distinguished individuals in American Pathology and Hospital Administration have been selected.

The Institute is being co-sponsored by the Page and William Black Post-Graduate School of Medicine of the Mount Sinai School of Medicine. Participants may apply for Category One credit toward the Physician's Award of the American Medical Association.

Communications should be addressed to the Office of the Program Chairman, New York State Society of Pathologists, 445 Tremont Street, North Tonawanda, New York, 14120.

Reservation forms for rooms at the Headquarters Hotel, The Biltmore, will be sent to all registrants.

OB-GYN Clinical Meeting

The American College of Obstetricians and Gynecologists will meet May 21-24 in Bal Harbour, Florida at the Americana Hotel. The 21st annual clinical meeting will feature formal papers, reports on current investigations, and specialty meetings on Community Health, Maternal and Perinatal Medicine, Oncology, Pediatric and Adolescent Gynecology, and Psychosomatic Obstetrics and Gynecology.

The registration fee for non-members is $125. For additional information, contact Donald F. Richardson, Associate Director, American College of Obstetricians and Gynecologists, One East Wacker Drive, Chicago, Illinois 60601.

Joint Position Statement Adopted By Physicians and Nurses

(Editor's Note: Published below is the Joint Position Statement of the West Virginia State Medical Association and the West Virginia Nurses Association, Inc., which was approved by the Council of the State Medical Association following development of same by a Joint Committee of the two Associations).

PREAMBLE

The increasing demands for health care make essential the optimum utilization of the physician and nurse.

This statement sets forth the commitment of the West Virginia State Medical Association and the West Virginia Nurses Association to increase the significance of nursing as a primary component in the delivery of health care.

See Editorial on Page 93

Efforts to effect a more productive relationship must embrace the total medical-nursing community and will depend upon effective communication and coordination through formal and informal channels.

The following specific principles will guide the activities of the West Virginia State Medical Association and the West Virginia Nurses Association in the area of physician-nurse relationships.

PRINCIPLE 1: Delivery of health care is by its nature a team operation that incorporates the two primary health care professions (medicine and nursing) and various other health care disciplines.

The professional nurse is the logical person to collaborate with the physician in the management of the patient care.

A team operation requires new definitions of responsibility and authority.

The degree of professional authority vested in the M. D. or R. N. should be related to competence, experience and education, as well as to licensure. For the benefit of the patient, it is critical in the decision-making process that there be a known specific point of accountability and that the person having that responsibility also have commensurate authority. The physician as the logical leader having definitive legal authority in matters of medical care must accept this ultimate accountability to the patient.

The West Virginia State Medical Association supports the additional concept that the professional nurse should share authority with the physician. The nurse contributes to management decisions in patient care, carries out those decisions in the nurse's sphere of competence, takes responsibility and authority for nursing care of the patient, and makes decisions in the nursing aspects of the patient's care within the over all patient-care context agreed upon. The nurse, therefore, can take a

logical place at the physician's side when associated with him in patient-care responsibilities.

PRINCIPLE 2: The West Virginia State Medical Association and the West Virginia Nurses Association recognize the need for and will collaborate to facilitate the expansion of the role of the nurse in providing health care for the patient.

Professional nurses are qualified to assume greater health care responsibilities, thereby enhancing the scope of services available to the public.

The addition of nurses especially prepared by short periods of intensive training would provide much needed services, enhance nursing as a profession, and extend the hands of the physician. The broad definitions in the state practice acts allow for growth in the scope of medical and nursing practice.

This principle builds on a history of translating certain medical services into nursing functions. It has long been recognized that physicians depend on nurses to help deliver basic care. As health service potentials and patient demands have grown this dependence has become even more pronounced. Recent research and demonstration projects have proved the feasibility of enlarged responsibility for nurses in delivery of health care. The intention is to extend systematically and on a major scale those efforts found to be effective by experience.

The *totality* of the service rendered to the patient will be improved by better utilization of physician and nurse within a *system* of care. Careful reviews of experimental projects and examples in medical practice indicate these benefits: (1) patients will receive more time and attention because basic service procedures can be increased and amplified; (2) patients' self care and potential will be increased and amplified; and (3) the physician is allowed to concentrate on those matters demanding his singular skill and provides him with better opportunity to increase proficiency.

Physicians' services augmented by nursing services will increase *availability* of service to those sectors of the population without adequate health care.

PRINCIPLE 3: The West Virginia State Medical Association and the West Virginia Nurses Association encourage and support various levels of education for professional and practical nursing and emphasizes continuing education for all nurses.

The medical and nursing professions will collaborate in the development of education resources.

As the role of the professional nurse expands in health care, the practical nurse's role will need to be redefined in order to be expanded. Such redefinition will require collaboration with the Practical Nurses Association of West Virginia, Inc.

Considerable effort is needed to integrate effectively the present system of nursing education so that persons of ability and motivation can more readily achieve their highest level of competency and status. Credit for related courses, challenge examinations, other educational sources, and recognition for achievement in clinical fields are mechanisms which would facilitate and increase proficiency and career mobility.

Inherent in this recommendation is development of effective systematic evaluation of these programs.

PRINCIPLE 4: Patient care will be better served if nurses are extensively involved in the delivery and planning of health care.

The rapid growth of health care has accentuated a trend toward placing more and more administrative responsibility on the nurse, therefore reducing her role in direct patient care. The West Virginia State Medical Association will join with the West Virginia Nurses Association to influence the development of nursing services aimed at increased involvement in direct patient care.

There should be active participation by nurses on committees serving the community as well as within institutions organized to provide health services. Steps should be taken within institutions to have the nurses participate on committees of the medical staff which focus on patient care—utilization review, infection control and the like.

At the community level steps should be taken to have nurses assume active roles in comprehensive health planning, community health and other programs and activities concerned with health care. The goal is a strong professional alliance in the delivery of health care.

ACS To Meet At The Greenbrier

The Spring Meeting of the West Virginia Chapter, American College of Surgeons, will be held May 3-5 at The Greenbrier, White Sulphur Springs.

D. F. Milam, M. D.

The principal speaker will be Dr. David C. Sabiston, who will present two papers: "Current Concepts in the Diagnosis and Management of Pulmonary Embolism," and "Surgery of the Coronary Circulation."

Other speakers and their topics will include: "Volvulus of the Sigmoid in a Two-Year-Old Male," Dr. T. H. Chang; "Gastroscopy," Dr. Raymond C. Bonnabeau, Jr.; "Safety Problems Encountered With Modern Electrosurgical Units," Dr. D. F. Milam, and "Mid-Facial Fracture Management and Results," Dr. Ghasson A. Khalil.

State Woman's Auxiliary To Meet At Oglebay Park April 25-26

The Woman's Auxiliary to the West Virginia State Medical Association will hold its Spring Board of Directors' Meeting and Workshop April 25 and 26 in Wheeling at Wilson Lodge, Oglebay Park.

Following registration on Wednesday from 1 to 2 P. M., there will be a meeting of the Board of Directors, composed of state officers, state committee chairmen, and component auxiliary presidents. There will be a social hour beginning at 6:30 P. M. and a dinner at 8 P. M.

Thursday's schedule will begin with a Continental Breakfast at 9 A. M., followed by a workshop for all state and county officers and chairmen. The workshop will be under the direction of Mrs. J. Dennis Kugel, President-Elect. All county President-Elects are urged to attend.

Delegates to the American Medical Association Convention in New York, June 23-28, will be elected at the Spring Board Meeting.

Pediatrics Course at U. K.

The University of Kentucky College of Medicine will offer a two-day course on pediatrics on May 24 and 25. The program chairman is Nancy Holland, M. D. The registration fee is $75; 12 hours of AAFP credit have been requested.

The course is aimed at pediatricians and family physicians who are interested in reviewing and examining newer concepts in this area. From 10 to 15 topics will be presented by UK faculty and guest faculty.

For further information, contact Frank R. Lemon, M. D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Dr. A. Thomas McCoy, right, of Charleston, greets Rep. Gerald Ford (R., Mich.), House Minority Leader, who delivered a dinner address at the American Medical Association's first national Leadership Conference held recently in Chicago. Doctor McCoy is President Elect of the State Medical Association.

Two Medical Appointments Announced By WVU

Dr. Clark K. Sleeth, Professor of Medicine and former Dean at the West Virginia University School of Medicine, has agreed to serve as Acting Chairman of Family Medicine until a permanent chairman is appointed, Dean Frank W. McKee announced recently.

Clark K. Sleeth, M. D.

Hartwell G. Thompson, M. D.

It later was announced, by WVU President James G. Harlow, that Dr. Hartwell G. Thompson has been named Dean of the WVU Medical Center's newly established Charleston Division. Doctor Thompson was Professor and Chairman of the medical center's Department of Neurology from 1964 until he went to the University of Pennsylvania in 1969.

The search for a chairman has been under way since the establishment of a Family Practice Residency Training Program and clinic at WVU was approved by the West Virginia Board of Regents last April.

Since that time, Dean McKee explained, five or six persons recommended by the search committee have been interviewed.

"The demand for experienced physician-educators qualified for this type of program is great and the supply limited," Dean McKee added.

The concept of post-medical school training in family practice is relatively new. Of the 108 programs now existing in the United States, only 28 are affiliated with schools of medicine; the others are programs of independent hospitals.

Doctor Sleeth's main function as Acting Chairman will be to lay the groundwork for the program and its clinic, Dean McKee said.

"Doctor Sleeth is a careful and methodical planner," he added. "His work will give the program more visibility."

Five Areas Stressed

The Family Practice Program at WVU will stress five main areas. They are: treatment principally on an outpatient basis; treatment of the family unit through its individual members; health maintenance in addition to episodic crisis care; research and evaluation of methods of health delivery; continuing education as required by the American

Board of Family Practice to Achieve and maintain certification.

Doctor Sleeth sees the development of the residency program as the most immediate need. A family practice residency will consist of three years of specialty training past the M. D. degree. No internship will be required for those entering the program.

In addition to postgraduate training, some content directly related to family practice will be included in the curriculum for the first three years of medical school, and fourth-year students will be given elective opportunity to work in a family practice setting, Doctor Sleeth explained.

Learning and training opportunities will be afforded by a clinic at the Medical Center for which 5600 square feet of space has been set aside.

The clinic will be a departure from other clinics at University Hospital which with few exceptions function as referral facilities.

"The matter of enrolling families in our practice panel will have to receive careful consideration and be done with the cooperation of the practicing professionals in Morgantown and surrounding areas," Doctor Sleeth said.

July, 1974, Target Date

Since most prospective residents have already made their commitments for July of this year, Doctor Sleeth believes July, 1974 will be the earliest date that the program will become active.

Once established, the program must be accredited by the American Medical Association and the Board of Family Practice. Those completing residencies will then be eligible to take examinations for board certification.

Doctor Sleeth said that four residents a year would be the maximum to be recruited now, but this number could increase as the program grows.

Doctor Sleeth has had wide experience in planning, setting up and implementing programs for the School of Medicine. He served as Dean from 1961-70 during the formative years.

A native of Marion County, he received an A. B. Degree and completed his first two years of medical school at WVU. He was granted his M. D. Degree by the University of Chicago.

Doctor Sleeth had three faculty appointments at WVU before completing his medical training. After receiving his B. S. Degree in medicine, he was named an Assistant in Physiology and the next year served as an instructor in the same department. In 1938-39, he was an Assistant Professor of Pathology before going to Henry Ford Hospital in Detroit for his internship and residency.

In 1941, he was named Assistant Professor of Medicine and has taught at WVU since with the exception of four years spent in the U. S. Army Air Force during World War II. He was appointed Professor of Medicine in 1961.

Doctor Sleeth is the author or co-author of numerous articles for professional journals. Much of his research has been in gastrointestinal physiology.

In 1966, Doctor Sleeth was awarded an honorary Doctor of Science degree from Davis and Elkins College.

Looking Back 10 Years . . .

Dr. James S. Klumpp of Huntington, left, Parliamentarian and a past President of the State Medical Association, received a plaque from Dr. D. E. Greeneltch of Wheeling in recognition of his "Outstanding Contribution to Medicine on the Local, State and National Levels."

Dr. Thompson To Start In Late Spring

Doctor Thompson is expected to assume his new duties in the late spring. President Harlow described him as uniquely qualified to direct the Charleston Division, which will be associated with the year-old Charleston Area Medical Center.

"Dr. Thompson knows West Virginia," President Harlow observed. "As a former chairman at WVU, he's familiar both with medical education and the delivery of health care in the state."

Don L. Arnwine, President of Charleston Area Medical Center, said, "The filling of this position is extremely significant to medical education in Southern West Virginia and Doctor Thompson is an excellent choice. We at CAMC are simply delighted."

Doctor Thompson currently is medical professor and administrator at the University of Pennsylvania. A Connecticut native, he is a graduate of Yale University and the Cornell University Medical College. He received post-graduate training in Neurology at Columbia-Presbyterian Medical Center in New York City and later was a special trainee at the National Institute of Neurological Disease and Blindness. In 1960 he was certified in Neurology by the American Board of Psychiatry and Neurology.

Before joining the WVU faculty, Doctor Thompson taught at Columbia University's College of Physicians and Surgeons and at the University of Wisconsin Medical School.

PG Fractures Course In Chicago

The Seventeenth Annual Postgraduate Course on Fractures and Other Trauma will be held May 9-12 in Chicago at the Sheraton-Chicago Hotel by the Chicago Committee on Trauma of the American College of Surgeons.

The guest speaker will be Dr. Rocco A. Calandruccio, Associate Professor of Orthopaedic Surgery, University of Tennessee; Campbell Clinic, Memphis. Doctor Calandruccio will speak on pathophysiology of non-union, fractures of the femoral hip, posterior dislocation of the shoulder, and lesions confused with lumbar discs.

Altogether, 36 persons will comprise the faculty, representing many of the medical schools in the Chicago area. The program is intended for all who care for injured patients, and is acceptable for 28-and-one-half elective hours by the American Academy of Family Physicians. The registration fee is $140. For further information contact the American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

ABFP Exam October 20-21

The American Board of Family Practice has announced that it will give its next two-day written certification examination on October 20-21 in various centers throughout the United States. Information regarding the examination can be obtained by writing:

Nicholas J. Pisacano, M. D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

The deadline for receipt of applications in the Board office is August 1.

International Symposium

The International Symposium on "Oxygen Transport to Tissue" will be held April 22-28 at Clemson, South Carolina. The symposium is sponsored by the Medical University of South Carolina and Clemson University.

More than 160 scientists from the United States, Europe and Japan will be attending the meeting. The overall objective of the symposium will be to evaluate the advances that are being made in understanding the supply of oxygen to tissue.

For further information contact Charles B. Gudaitis at the Medical University of South Carolina, 80 Barre Street, Charleston, South Carolina 29401.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

April 2-4—ACS (Spring), New York City.
April 2-7—Am. Col. of Rad., San Francisco.
April 6-7—Am. Otol. Soc., St. Louis.
April 6-8—W. Va. Chapter, AAFP, Morgantown.
April 6-8—Am. Soc. Int. Med., Chicago.
April 11—Wheeling Clinic Educat. Meeting, Wheeling.
April 7-12—Am. Col. of Allergists, Atlanta.
April 8-12—Am. Assn. of Neu. Surg., Los Angeles.
April 8-13—ACP, Chicago.
April 16-18—Am. Assn. for Thoracic Surgery, Dallas.
April 18-21—W. Va. Academy of Ophth. and Otol., White Sulphur Springs.
April 23-28—Am. Acad. of Neurology, Boston.
April 25-27—Maryland Medical, Baltimore.
April 25-27—Am. Surg. Assn., Los Angeles.
April 25-27—Med. & Chirurgical Faculty of Md., Baltimore.
April 27-29—N. Y. State Path., N. Y. City.
April 29-May 2—Am. Soc. for Head and Neck Surgery, Hot Springs, Va.
May 2-5—ACS, W. Va. Chapter, White Sulphur Springs.
May 2-5—Am. Gyn. Soc., Colorado Springs, Colo.
May 4-5—W. Va. Ob. & Gyn. Clinical Workshop, Charleston.
May 5—W. Va. Soc. of Anesth., Morgantown.
May 7-9—Am. Col. of Sports Med., Seattle.
May 7-11—Am. Psych. Assn., Honolulu.
May 7-11—Ohio State Med. Assn., Columbus.
May 13-17—Am. Urol. Assn., New York City.
May 16-20—Am. Ped. Soc., San Francisco.
May 20-23—Nat. TB & RD Assn., New York City.
May 21-24—Am. Col. of Ob. & Gyn., Bal Harbour, Fla.
May 21-24—Am. Thoracic Soc., New York City.
May 28-30—Am. Ophth. Society, Hot Springs, Va.
June 22-23—Am. Diabetes Assn., Chicago.
June 24-27—Am. Assn. of Plastic Surgeons.
June 24-28—AMA, New York City.
Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.
Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.
Sept. 18-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 28-Oct. 4—AAFP, Denver.
Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.
Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.
Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.

1974

Jan. 19-20—Mid-Winter Clinical Conf., Charleston.

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

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Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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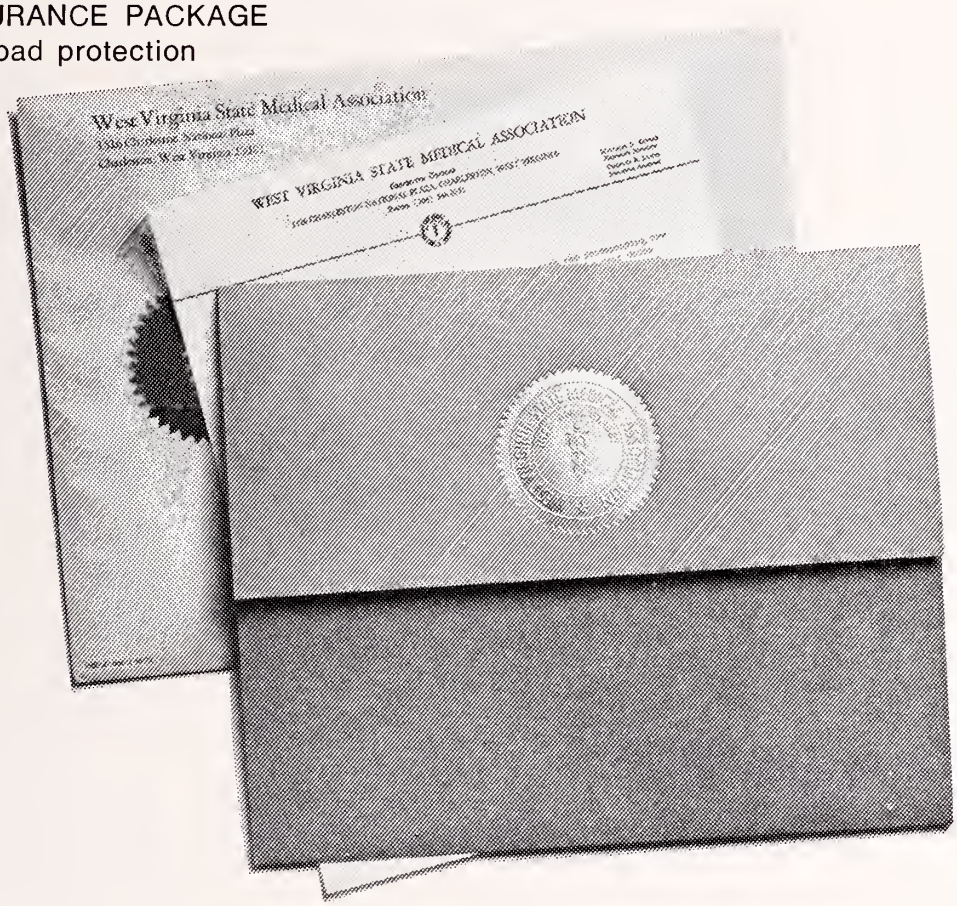

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WVU Medical Center
–News–

THE first kidney transplant operation in West Virginia was performed last month at West Virginia University's Medical Center.

The patient, 18-year-old Deborah Burnside of Hometown in Putnam County, received one of her mother's kidneys on March 5. Miss Burnside was in satisfactory condition in WVU Hospital's new Intensive Care Unit as this issue of the *Journal* went to press.

Dr. E. Schrae LaPlante headed the team of surgeons who performed the transplant. Doctor LaPlante is Assistant Professor in the Department of Surgery, WVU School of Medicine.

Deborah's mother, Mrs. Helen Burnside; her father, Thomas; and her brother, David, all offered to be the kidney donor. Tests determined that Mrs. Burnside's kidney provided the best tissue match for her daughter.

Deborah was referred to WVU Medical Center by Dr. Mary Lou Lewis, a nephrologist at Charleston Area Medical Center, Memorial Division. Doctor Lewis, who supervised Deborah's dialysis and preparation for surgery in Charleston, was at University Hospital during the operation to assist with her patient's care.

Costs for Deborah's care are being financed by the Division of Crippled Children's Services, West Virginia Department of Welfare, which has been working with Doctor Lewis, Charleston Area Medical Center and WVU Medical Center to develop a statewide program for renal dialysis and kidney transplants at University Hospital.

The WVU Medical Center's nephrology program in the Department of Medicine is expected to begin in July.

In October, Gov. Arch A. Moore Jr. joined with legislative and medical leaders to announce the beginning of a state-supported artificial kidney and kidney transplant program to be financed initially with $250,000 provided by the 1972 Legislature.

For several years some West Virginia doctors, including Dr. D. Sheffer Clark of Huntington and Charleston's Doctor Lewis, have been providing treatment with the artificial kidney (hemodialysis) for patients under their care.

The West Virginia Chapter of the National Kidney Foundation, the Auxiliary to the West Virginia Hospital Association, the State Board of Health, the American Kidney Fund, and other groups and agencies also have joined in the efforts to provide adequate care for West Virginians with kidney diseases.

- **Compiled from moteriol furnished by Mrs. Mory Ellin Wylie, Director, Medicol Center News and Informotion Services, Morgontown, W. Va.**

$8,000 Award Granted

West Virginia University Medical Center has received an $8,000 award from The Deafness Research Foundation of New York City to continue a research project in otolaryngology.

The grant, renewed for the third time, will be used to support the work of Dr. Philip M. Sprinkle, Professor and Chairman of the School of Medicine's Division of Otolaryngology, and Dr. Robert W. Veltri. Doctor Sprinkle's research laboratory, under the direction of Doctor Veltri, is investigating the microbiology and immunology of inflammation of the middle ear. Doctor Veltri is an Associate Professor of Microbiology and Otolaryngology.

Endorsed by leading professional groups in otology and otolaryngology, The Deafness Research Foundation is the only national, voluntary agency primarily devoted to aiding research into the cause, treatment and prevention of hearing impairment and other ear disorders.

The WVU grant is one of 31 awards, totaling more than $300,000, that the organization has made this year.

Dr. Shane Elected To Research Group

Dr. Stanley Shane, an Associate Professor of Medicine and member of the West Virginia University School of Medicine faculty since 1965, was elected to membership in the Central Society for Clinical Research at that organization's meeting recently in Chicago.

In research, Doctor Shane is particularly interested in calcium metabolism and parathyroid gland function.

Originally composed of selected members of departments of medicine and pediatrics throughout the Midwest, the society several years ago added West Virginia to the included area.

Doctor Shane joins three other members of the WVU Medical Center faculty who belong to the organization. They are Dr. Edmund B. Flink, Professor and Chairman of medicine; Dr. John E. Jones, Professor of Medicine and Chairman of Metabolism-Endocrinology; and Dr. Albert S. Klainer, Professor of Medicine and Chief of Infectious Diseases.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association took to Congress its protest against retention of controls over physicians in phase III of the economic stabilization program.

In a statement to the Senate Committee on Banking, Housing and Urban Affairs, which was considering a one-year extension of statutory authority for the program, the AMA cited the "highly discriminatory" treatment of physicians and other health care providers under the program despite their cooperation and "laudable record of self-restraint."

"We have questioned the wisdom of many of the policies which have been initiated in the various regulatory phases since August of 1971," the AMA statement said. "In particular, we have objected to certain aspects because of the highly discriminatory treatment accorded health care providers. This discrimination has been even heightened under phase III of the Administration's program. On January 11, 1973, mandatory wage and price controls were suspended for most sectors of the economy but were continued to be enforced upon health care providers. Our opposition to this discrimination does not stem from self-interest, nor is it based solely upon invidious comparison with those segments of the economy no longer subject to mandatory control. The question we raise here is more fundamental. It is submitted that the capricious imposition of controls on select groups only serves to frustrate the basic objectives of the stabilization program itself. If regulation is to be effective, it must recognize the interrelationships existing within the economy in general. Without such accomplishment the intent of the law will be frustrated.

"Physicians' fees constitute a relatively small percentage of the gross national product (less than 1.5 per cent) and they constitute a small factor in the consumer price index weighting structure (less than 1.8 per cent). Given the relatively slight impact of this factor upon the economy as a whole, the suspension of mandatory controls would not work counter to the goals of the economic stabilization program. Conversely, continued controls could not be expected to yield meaningful restraints throughout the balance of the economy. The continuation of mandatory controls, therefore, does not appear to be consistent with the letter or spirit of the economic stabilization act.

"The Congress found in enacting the economic stabilization act that prompt judgments and actions by the executive branch of the government were necessary to meet extreme economic fluctuations. The Congress, however, directed the President to conduct such emergency programs in a fair and equitable manner and to make such adjustments as may be necessary to prevent gross inequities. Standards established under an emergency program must comply with the criteria of section 203 (b) of the act which provides, among other things, that such standards shall be "generally fair and equitable" and that the program must call for "generally comparable sacrifices by business and labor as well as other segments of the economy."

"We emphasize that this statutory authority presumes the existence of an economic emergency and authorizes a coherent and comprehensive governmental response. Only a system of price stabilization effective at all levels of production and consumption and having equitable incidence within the economy should be countenanced. To invoke controls for one activity without the reasonable expectation of achieving a result having universal application is to employ the statute in a punitive manner. Punitive treatment of health care professionals is neither sanctioned by law nor warranted by the record.

"It is apparent from the physician component of the consumer price index that the medical community has fully complied with efforts to curb inflation during phase I and II of the new economic policy. In the period from August 1971 to December 1972 the all items category, as measured by the consumer price index, rose at a rate of 4.2 per cent, the all services component at the rate of 4.6 per cent, while physicians' fees rose only 3.2 per cent. In the period from November 1971 to December 1972 (i.e., during the 14 months of phase II) the all items category rose 3.8 per cent, the price of all services rose at a rate of 3.8 per cent while physicians' fees rose at a rate of 2.6 per cent. For the calendar year 1972, physicians' fees increased only 2.1 per cent. This percentage is below the 2.5 per cent annual goal set by the Health Services Industry Committee of the Price Commission, and represents a rate of increase of only one third the rate of increase prior to phase I. Since the goal of the economic stabilization program was to halve the rate of inflation, the record achieved by physicians surpassed considerably the expectations of the program."

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Obituaries

DELMER JENCKS BROWN, M. D.

Delmer Jencks Brown, M. D., a Parkersburg specialist in internal medicine, died on February 25 in Glendale, California. He was 65. Doctor Brown had gone to California to visit his daughters and sisters following his partial retirement. He was planning to return to Chillicothe, Ohio to work in the Veteran's Administration Hospital.

Doctor Brown was on the staffs of Camden-Clark Memorial Hospital and St. Joseph's Hospital in Parkersburg. He was a member and past President of the Parkersburg Academy of Medicine (1968).

A native of Lincoln, Nebraska, Doctor Brown received an A. B. Degree from Pacific Union College at Angwin, California. He received his M. S. Degree from the University of Southern California at Los Angeles, and his M. D. Degree in 1940 from Loma Linda University School of Medicine at Loma Linda, California.

He interned at the Los Angeles County General Hospital and did his residency and post-graduate work at Walter Reed General Hospital in Washington, D. C.

He was a Diplomate of the American Board of Internal Medicine.

Doctor Brown was a member of the West Virginia State Medical Association, the American Medical Association, and the American College of Physicians. He was Treasurer for the West Virginia Diabetes Association.

He was commissioned as a First Lieutenant and discharged from the U. S. Army as a Major following his 1941-46 tour of duty.

Survivors include the widow, Dr. Marion S. Brown; two daughters, Mrs. Darrell Lang and Mrs. Arthur Smith, both of Glendale; two sisters, Mrs. Frances Barnard of Bakersfield, California and Dr. Emily Jane Brown of Glendale; and three grandchildren.

* * * *

JAMES R. GATHERUM, M. D.

James R. Gatherum, M. D., of Pocahontas, Virginia, a former general practitioner in West Virginia, died on February 9 at Bluefield, West Virginia in Bluefield Sanitarium. He was 59.

A native of Athens, West Virginia, Doctor Gatherum received an A. B. Degree from Concord College there in 1933. After teaching at schools in Coalwood and Peterstown, he entered the Medical College of Virginia in 1942. He received his M. D. Degree in 1946 from that institution, where he also interned. He served his residency at Bluefield Sanitarium after two years' duty in the U. S. Air Force as medical officer. He then went to Richwood and practiced medicine at the McClung Clinic for seven

(Continued on Page xviii)

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years. He then returned to Mercer County and practiced in Athens for 15 years.

Three years ago, Doctor Gatherum returned to Bluefield Sanitarium as a house physician and, in November, 1972, opened an office in Pocahontas.

Surviving are his widow; three daughters, Mrs. James R. McLaughlin of Roanoke, Virginia, and Riley Beth Gatherum and Dorothy Ruth Gatherum, both of Athens; one brother, Dr. David N. Gatherum of Bluefield; and two grandchildren.

* * * *

FOREST A. CORNWELL, M. D.

Dr. Forest A. Cornwell, Project-Medical Director for the Mountaineer Family Health Plan, Inc. in Beckley, died on February 24 at his home there. He was 52.

Doctor Cornwell served as President of the Raleigh County Medical Society in 1969. He was President of the medical staff of Beckley Appalachian Regional Hospital in 1962-63 and was a former Chief of Pediatrics at that hospital. He also served at Miners Memorial Hospital and the Southern West Virginia Clinic.

He was one of the five incorporators and charter members of the Mountaineer Family Health Plan, Inc., serving as President of the corporation and Chairman of the Board of Directors through 1969. He was a member of the Board of Directors of the Raleigh County Community Action Association, a representative of the West Virginia State Medical Association to the West Virginia Joint Council On Teaching Hospitals, and was President of the West Virginia Heart Association in 1970.

Doctor Cornwell was a native of Dallas, Texas. He received his B. S. Degree in Medicine and his M. D. Degree from the University of Kansas. He interned at the U. S. Naval Hospital, Bainbridge, Maryland, and was a resident at Children's Mercy Hospital in Kansas City, Missouri, and the Children's Medical Center at Dallas. He did postgraduate work in pediatrics at Harvard Medical School, Children's Medical Center, in Boston. He practiced pediatrics in Dallas before coming to Beckley in 1956.

Doctor Cornwell was a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. He was a member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He was a veteran of World War II and the Korean Conflict, holding the rank of Commander in the Medical Corps, U. S. Naval Reserve.

Surviving is his mother, Mrs. Pearl Cornwell, of El Dorado, Kansas.

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Joann Green, R. N.
Juanita Stone, R. N.
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Administrotion:
Lester L. Cline, Manager
Henry L. Castilow, Asst. Mgr.

DENNIS J. CRONIN, M. D.

Dr. Dennis J. Cronin, a Huntington physician for 63 years, died on February 7 in a hospital there after a brief illness. He was 84.

Doctor Cronin was a native of Pawcatuck, Connecticut. He received his M. D. Degree in 1910 from the University of Maryland and interned at Bellevue Hospital in New York City.

Doctor Cronin was a past President of the staff of St. Mary's Hospital in Huntington and was a member of the staff of Cabell-Huntington Hospital. He was a member of the Cabell County Medical Society, the West Virginia State Medical Association, the American Medical Association, and the American Association of General Practitioners.

Survivors include the widow; a son, John D. Cronin of Lexington, Kentucky; two daughters, Mrs. Helen Dineen of Columbus, Ohio, and Miss Anne J. Cronin of Cincinnati, Ohio, and three grandchildren.

Emergency Care Course

A course on "Emergency Care and Transportation of the Sick and Injured" will be held at Columbia, South Carolina April 18-20. For additional information, contact E. M. Lunceford, Jr., M. D., 2709 Laurel Street, Columbia, South Carolina 29204.

County Societies

McDOWELL

A movie and program on venereal diseases were presented by two members of the West Virginia Department of Health at the February 14 meeting of the McDowell County Medical Society in Welch at Stevens Clinic Hospital. The presentation, followed by a question-and-answer period, was quite informative.

The Society approved payment to provide a campership for a diabetic child in response to a campaign by the West Virginia Diabetes Association.

The Secretary made a motion that the By-Laws should be reviewed by the Society each year at its second meeting and that revised or amended copies of the By-Laws be distributed to each member. The motion was approved. Dr. John S. Cook, the President, then named to a committee for revision and study of the By-Laws Drs. Arthur Allen Carr,

(Continued on Page xx)

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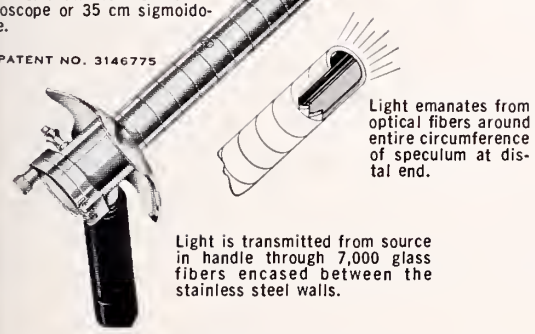

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* * * *

MERCER

Jerome Katz, Intermediate Court Judge of Mercer County, was the guest speaker at the meeting of the Mercer County Medical Society on February 19 in Bluefield at the University Club.

Judge Katz reviewed the problems of alcohol use in individuals who are brought to court. He said a clinic and special facilities for alcoholics are desperately needed in Mercer County, and felt that physicians should be instrumental in a solution of the alcoholic problem. The judge said alcohol is a definite factor in divorces, violent crimes and juvenile cases.

Dr. David F. Bell, Jr. reported on Comprehensive Health Planning and summarized the written priorities for health care in Mercer County. They are: financial support for a physicians recruitment program, an expansion program at the Princeton Community Hospital, and a coronary catheterization lab.

Dr. Edward Flynn was unanimously elected to membership.

The Society approved a donation of $50 to Camp Kno Koma for diabetic children.

MONONGALIA

Dr. Orlando Gabriele was guest speaker at the meeting of the Monongalia County Medical Society on February 3 in Morgantown. Doctor Gabriele's topic was "Angiography in Acute Medical Situations."

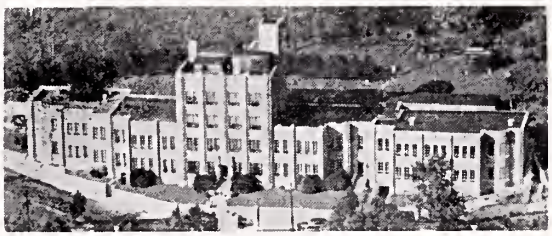
Fifty members were present.

The membership voted to ask Dr. Leslie F. McCoy to speak to our organization in the future regarding his program. Doctor McCoy is Director of Medical Services of the State Department of Vocational Rehabilitation.

The purchase of the West Virginia State Medical Journal for medical students who are residents of Monongalia County was approved.—H. Summers Harrison, M. D., Secretary.

International Health Conference

An International Health Conference will be held April 25-27 at Reston, Virginia at the Sheraton Inn & International Conference Center. New ideas on health care and its delivery and a fresh awareness of the underlying value assumptions involved in health care will be shared at the conference. The keynote address will be delivered by John Bryant, M. D., author of "Health and the Developing World." For additional information, contact National Council for International Health, c/o American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.



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Surgery:
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
T. H. Chang, M. D.

Gynecology and Obstetrics:
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Internal Medicine:
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Book Reviews

CURRENT DIAGNOSIS AND TREATMENT—By Marcus A. Krupp and Milton J. Chatton. 12th Edition. Lange Medical Publications, Los Altos, California. 1973. Price $12.00.

In the selection of a book, one must consider where it was written and who wrote it. However, there are always exceptions to a rule. This book is written by many well-qualified contributors (Ernest Jawetz et al.) in an area where our colleagues are affiliated with large medical centers with modern research facilities and they can observe and treat an adequate number of most diseases.

The volume is definitely practice-oriented and does not overlook any of the diseases commonly encountered by the general practitioner. There is a desire to be objective with constructive thought in this review.

Such a work should have a pictorial approach as well as a word picture in the diagnostic study such as in the sections on Endocrinology, Skin and Appendages. The camera is still an invaluable instrument as an aid in diagnosis.

Although the list of abbreviations on page 958 is a step in the right direction, I still think their use should be discouraged on hospital charts and in medical literature. They cannot only be unknown to the consultant and reader, but also misleading. The habit is not good scientific medicine.

The chapters on Fluid and Electrolyte Disorders, Respiratory Tract and Mediastinum, Heart and Great Vessels and Infectious Diseases are excellent. It should be mentioned in the diagnosis that the finding of the combination of right axis deviation and atrial fibrillation by electrocardiography almost always indicates Mitral Stenosis except rarely in cases of chronic constrictive pericarditis.

Also, the author failed to mention that the cardiac silhouette by x-ray in chronic constrictive Pericarditis is usually small or of normal size and not "usually moderately enlarged" as stated. A small heart is also found in Primary Addison's Disease.

The section on Infectious Diseases does not mention that such drugs as the sulfonamides are still the agents of choice and also of prophylaxis in the treatment of meningococcic meningitis as demonstrated during wars when this infection becomes more prevalent. The susceptibility of this infection to penicillin has been and still is variable.

The section on Medical Genetics is very good. There has been a rapid advance in the science of genetics in recent years. A knowledge of the basic principles is now a necessity for diagnostic purposes.

The book would be of increased value to the practitioner if there was a separate section on Tropical Diseases. As a result of increased foreign travel since World War II, one may be faced at any time with patients suffering from exotic diseases which call for early diagnosis and treatment.

Although it is often said the pace of "Medical Progress" has been accelerated since World War II, there is every reason to believe that the progress of scientific medicine is still slow because the newer diagnostic procedures and therapeutic agents should still be given a thorough trial in the modern clinical research centers before they are published for the benefit of the practitioner. Therefore, this good reference book need not be revised so frequently.

I am happy to add this book to my library and recommend it to the general practitioner.—Frederick Hnat, M. D., Mantoloking, New Jersey.

ORTHOPEDIC SURGERY IN THE ZONE OF INTERIOR—By Colonel William S. Mullins, MSC, USA, Fort Detrick, Frederick, Md. U. S. Government Printing Office, Washington, D. C. Final volume in the orthopedic subseries of the history of the U. S. Army Medical Dept. in World War II. 1973 Pp. 1099. Illustrated. Price: $12.25.

This large volume of 1,099 pages, containing 1,013 illustrations, five charts, 17 tables, is one of the finest in the group of World War II volumes issued from the Offices of The Surgeon General, Department of the Army.

The present Surgeon General of the Army and Lieut. General Leonard D. Heaton, his immediate predecessor, "consider the medico-military histories published in recent years as major contributions to the medical literature and perhaps our most lasting contribution."

Of the two series of these volumes, this one comes under the Professional or Clinical and Technical series.

This volume is a valuable personal possession and should be in the medical library of all non-military hospitals, and it is not intended entirely for orthopedic surgeons, but also for general surgeons and industrial surgeons as well. It is a splendid gift item.

The contents are timely and so well arranged your item of interest is quickly found. This volume is highly recommended.—Charles Frederick Fisher, M. D.

Medicare Costs Up

A medicare spokesman said that for a patient hospitalized 13 days, the average for beneficiaries, the cost could increase from $72 to a minimum of $158.40. About five million disabled or aged 65 or older will be hospitalized under medicare during the next fiscal year.

—Under medicare Part B, the voluntary doctor insurance that will cover 22.5 million persons next year, the patient would pay the first $85 of his doctor bills and 25 per cent of the remainder. He now pays a $60 deductible and 20 per cent of subsequent charges. For a patient with a $500 doctor bill, his share of the cost would increase from $148 to $188.75. About 11.6 million beneficiaries will receive medical care during the next fiscal year.

106th ANNUAL MEETING

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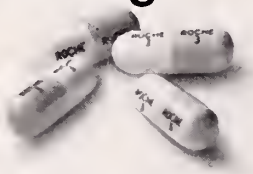

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Precautions: In the elderly and debilitate and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing grad ally as needed and tolerated. Not recommended in children under six. Though generally not rec ommended, if combination therapy with other psychotropics seems indicated, carefully conside individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibit and phenothiazines. Observe usual precautions presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulati and acute rage) have been reported in psychiatri patients and hyperactive aggressive children. Employ usual precautions in treatment of anxie states with evidence of impending depression; suicidal tendencies may be present and protecti measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been establish clinically.

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69 No. 5

MDS

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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MAY
1973

Vol. 69 No. 5

The
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Medical Journal

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Member 1973

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ngs: Age, weight, dosage, duration of therapy, ex- of concomitant diseases, and concurrent potent therapy affect incidence of toxic reactions. Care- struct and observe the individual patient, espe- e aging (forty years and over) who have ed susceptibility to the toxicity of the drug. Use effective dosage. Weigh initially unpredictable s against potential risk of severe, even fatal, re- . The disease condition itself is unaltered by the lse with caution in first trimester of pregnancy nursing mothers. Drug may appear in cord blood east milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

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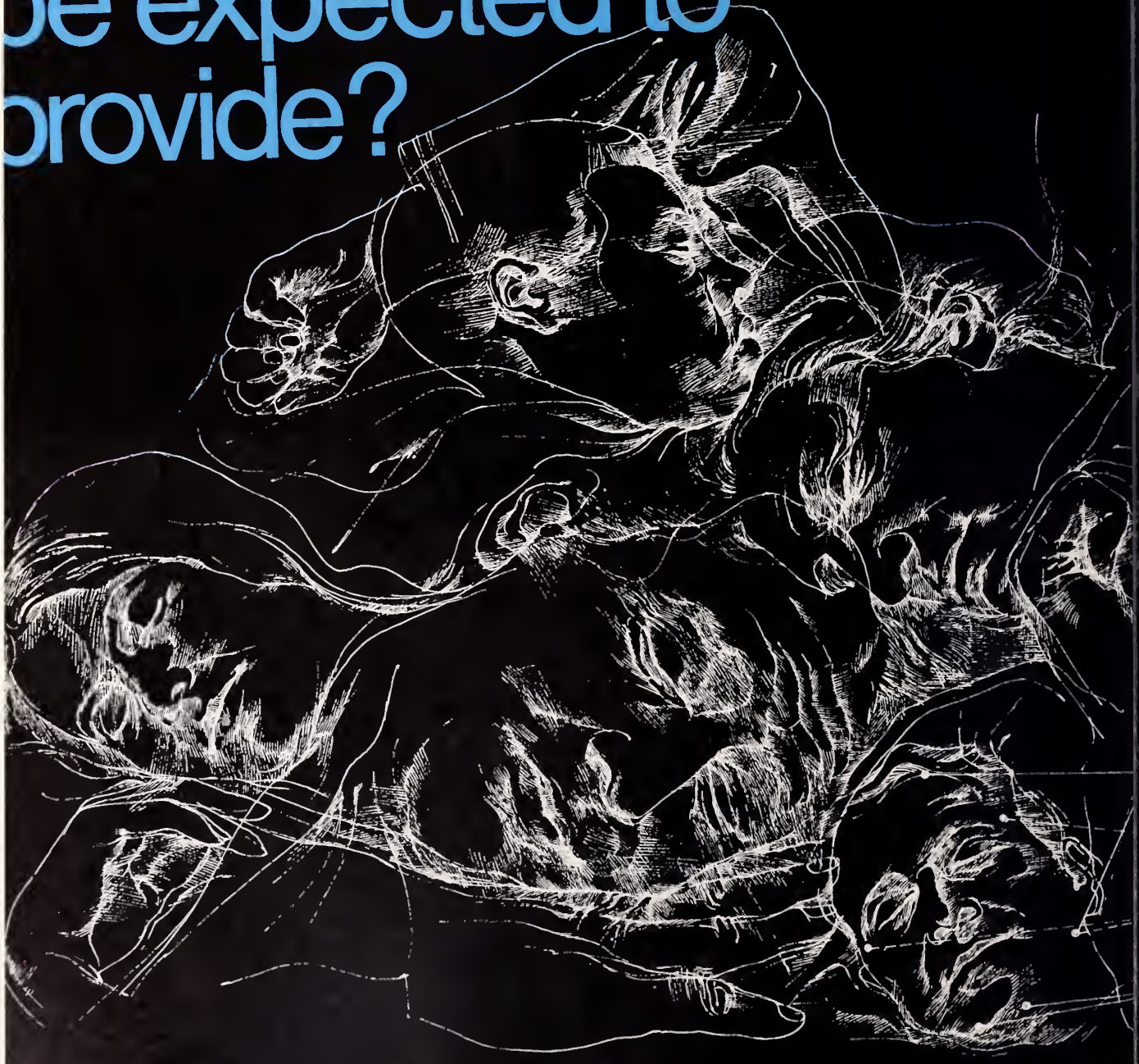

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effect. Employ usual precautions in patients who are severely depressed, or with

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ent depression or suicidal tendencies. iodic blood counts and liver and kid- function tests are advised during eated therapy. Observe usual precau- ns in presence of impaired renal or atic function.

verse Reactions: Dizziness, drowsi- s, lightheadedness, staggering, ataxia falling have occurred, particularly lderly or debilitated patients. Severe ation, lethargy, disorientation and na, probably indicative of drug intoler- e or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2

Advertisement

should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

Cost of Drugs

Insurance rates and hospital charges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned.* Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could allow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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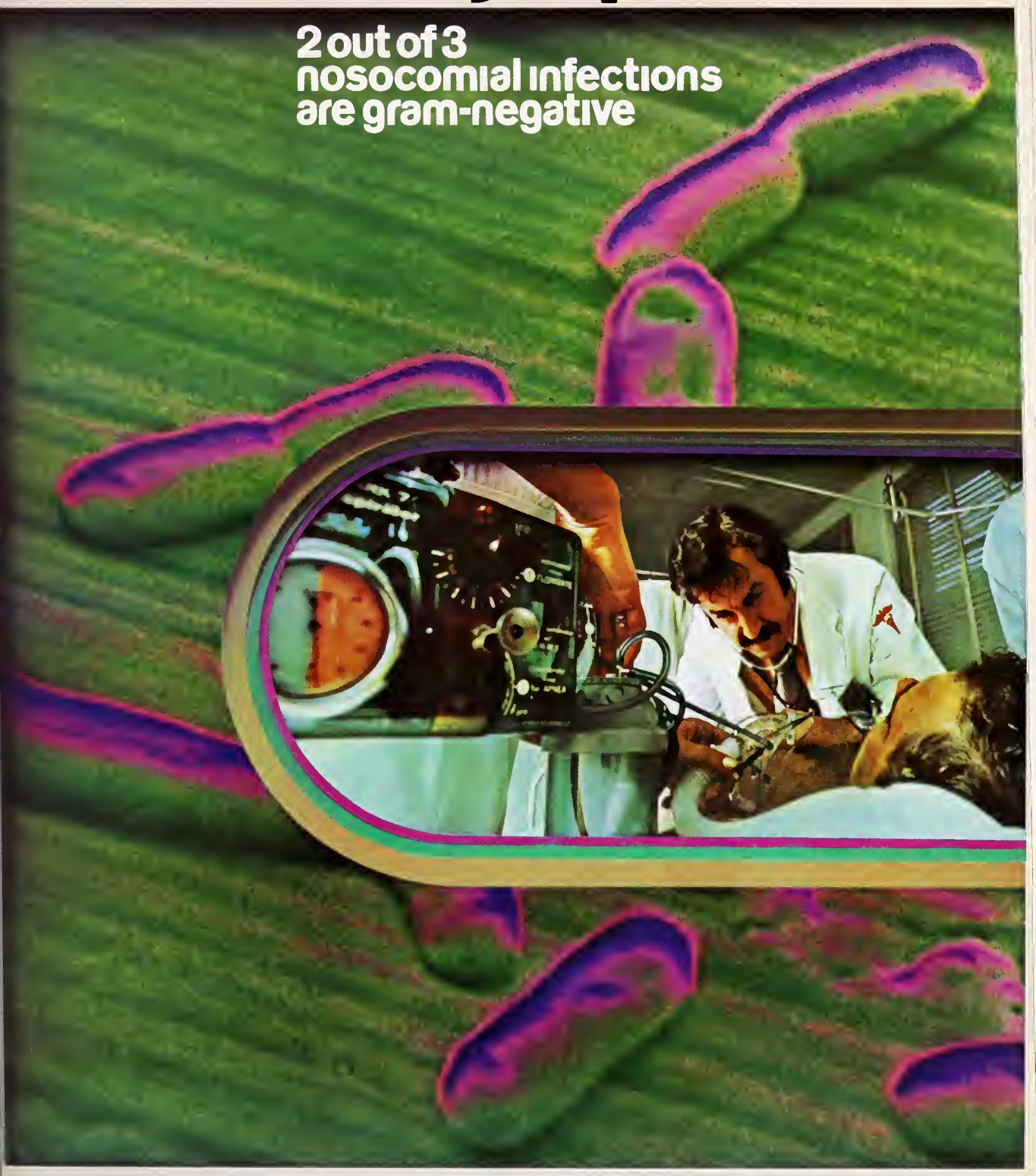

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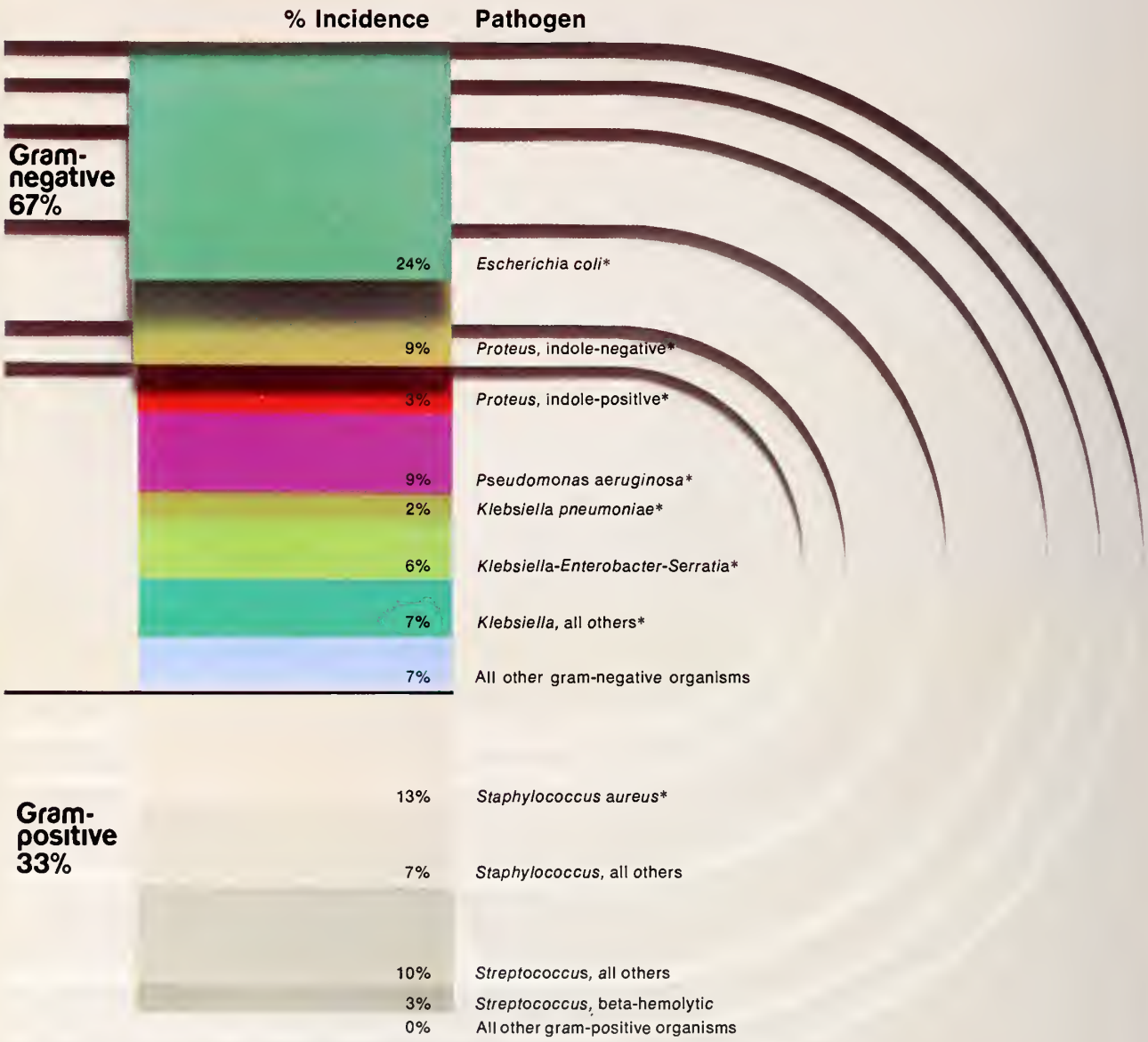

Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.

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A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella } species
Enterobacter } species
Serratia } species

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)*

*Due to susceptible organisms

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

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The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

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*Koch-Weser, J., *et al.*: *Arch. Intern. Med.*, *128*:399, 1971.

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The West Virginia Medical Journal

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Dermatofibrosarcoma Protuberans

(Report of a Case with Multiple Intrathoracic Metastases And a Brief Review of Six Others)

Raymond C. Bonnabeau, Jr., M. D.; Adel W. Armanious, M. D.; Charles B. Cuono, M. D.; William L. Mossburg, M. D.; and Joseph R. Lancaster, M. D.

Dermatofibrosarcoma protuberans is a rare tumor with an incidence of approximately one-tenth per cent.[7] This paper reports one case in which multiple (two) intrathoracic metastases originated from a primary tumor of the dorsum of the left foot following six local excisions, and briefly reviews the cases of six other patients seen during a 12-year interval (1960-1972) at the West Virginia University Medical Center (Table 1).

The Authors

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Case Report

J. C., (Case 7, Table 1), a 49-year-old white male, was initially admitted to the West Virginia University Medical Center on September 30, 1971, with a lesion of the upper lobe of the right lung. The lesion had been noted at another hospital two weeks earlier, where he had been

TABLE 1

DERMATOFIBROSARCOMA PROTUBERANS

West Virginia University Medical Center
7 Cases
(1960 - 1972)

No.	*Sex Age*	*Site*	*Year Noted*	*Year Last Resection*	*No. Recurrences*	*No. Metastasis*
1	F 76	Right Shoulder Posteriorly	1950	1959	1	0
2	M 60	RLQ Abdomen	1955	1965	1	0
3	M 44	Left Groin	1953	1965	0	0
4	F 43	Right Shoulder Anteriorly	1965	1966	0	0
5	M 48	Right Shoulder Anteriorly	1966	1968	0	0
6	F 42	Mid-Abdomen	1971	1972	0	0
7	M 49	Dorsum Left Foot	Most of His Life	1972	8	2

M — Male F — Female RLQ — Right Lower Quadrant

admitted for the seventh loeal excision of a primary dermatofibrosarcoma protuberans of the dorsum of the left foot. This tumor, which had been present for as long as the patient eould remember, had started to enlarge and become painful over the prior four-year period. Loeal excision of the mass had been repeatedly earried out despite multiple recurrences, because he had eonsistently refused any form of amputation.

The University Hospital admission chest x-ray revealed a round, cireumscribed coin lesion in the upper lobe of the right lung (Figure 1-a, 1-b, arrows), while tomography confirmed the presence of a solitary lesion in the seven-centimeter cut (Figure 1-c).

On October 19, 1971, an exploratory right thoracotomy was performed. As expected, a single lesion was all that was found and wedge resection of the right upper lobe mass was earried out. Microscopie examination of the specimen revealed it to be consistent with metastatic dermatofibrosarcoma protuberans (Figure 1-d). He made an uneventful recovery.

A routine chest x-ray taken December 28, 1971,

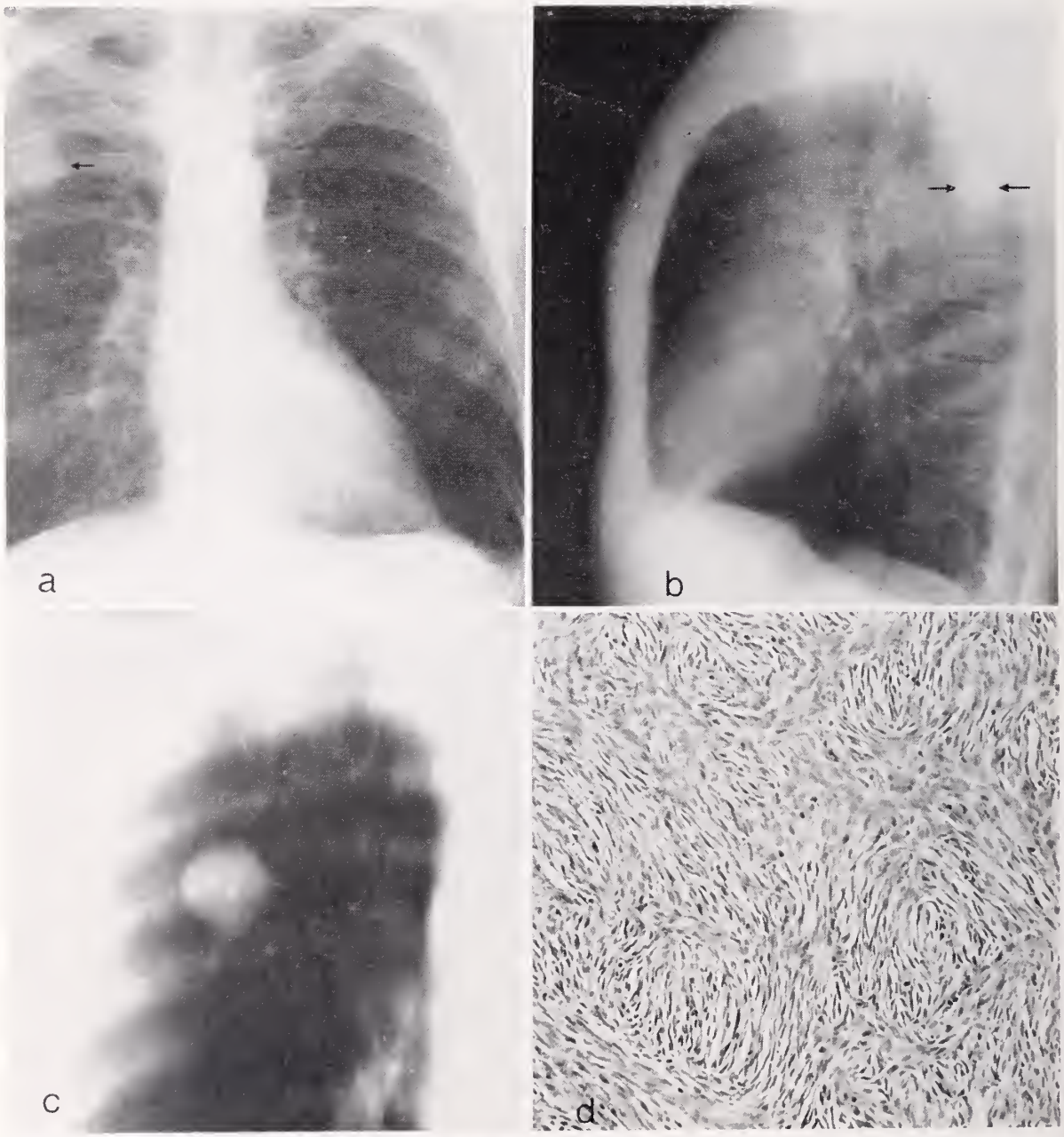

Figure 1. Photographs of the admission PA (a) and lateral (b) chest x-rays of the case reported in detail in this paper (Case 7, Table 1) A rounded density in the upper lobe of the right lung (arrows) can be seen. A tomogram (c) at the 7 cm. cut confirmed a solitary circumscribed tumor. Following right thoracotomy and wedge resection of the tumor, microscopic examination (d) revealed the lesion to be compatible with metastatic dermatofibrosarcoma protuberans (Compare with Figures 2-d and 3-b). At this point the primary lesion of the dorsum of the left foot had been excised locally seven times.

during a clinic visit, again showed a discrete lesion in the right chest (Figure 2-b, arrow). In retrospect, the mass had been present in a chest x-ray obtained the previous month (November 5, 1971), (Figure 2-a, arrow). At that time, however, it was incorrectly interpreted as being part of the postoperative changes seen in the upper lobe of the right lung. Comparison of these two sets of films showed an approximate tripling in size during this short interval. Tomography revealed the lesion to be situated on the parietal pleura overlying the third rib in the seven-centimeter cut (Figure 2-c). Another local recurrence (the eighth) of the primary dermatofibrosarcoma protuberans was also evident at this time on the dorsum of the left foot.

The patient was readmitted to the University Hospital where, on January 6, 1972, a second right exploratory thoracotomy, with resection of the tumor mass, overlying chest wall, and 12 cm. of the third rib, was carried out. This was followed by a Syme's amputation of the left foot to which the patient had finally given his consent.

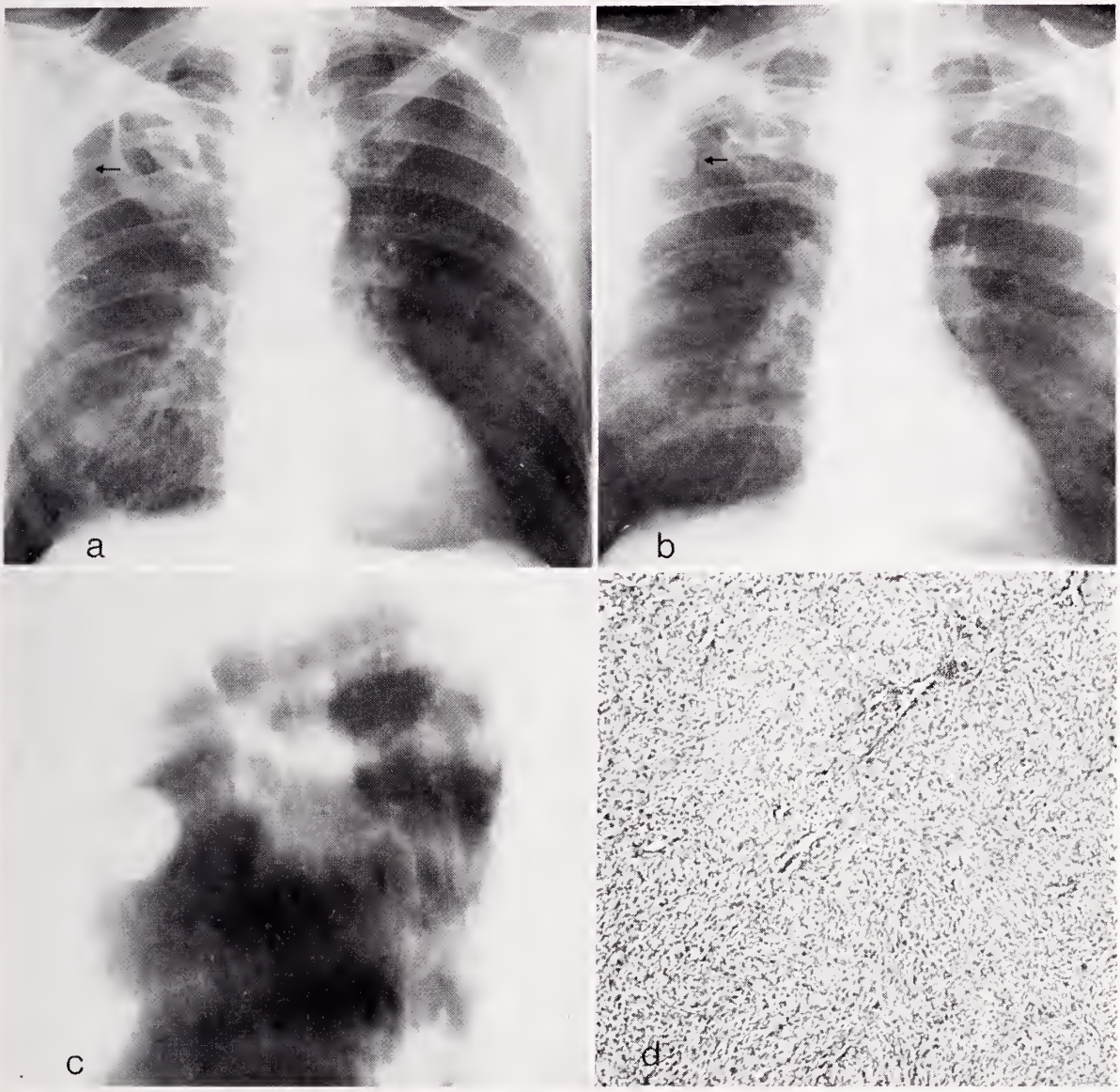

Figure 2-a. Photograph of a PA chest x-ray taken November 5, 1971, in the case of the patient presented in detail, following thoracotomy and right upper lobe wedge resection on October 19, 1971, of a dermatofibrosarcoma protuberans metastatic from a primary lesion of the dorsum of the left foot (Case 7, Table 1). The small rounded density (arrow) was mistaken for postoperative change in the right upper lobe and not for recurrent tumor.

2-b. Photograph of a chest film taken December 28, 1971. This showed a definite discrete recurrent lesion (arrow) which had almost tripled in size since the chest x-ray of November 5, 1971.

2-c. Photograph of the seven cm. tomogram cut of the right lung which confirmed an isolated, rounded, smooth lesion originating from the parietal pleural surface overlying the third rib.

2-d. Photomicrograph of the lesion after the patient's second right thoracotomy (Jan. 6, 1972) and resection of the tumor mass, chest wall, and 12 cm. of the third rib. The histological picture was again compatible with metastatic dermatofibrosarcoma protuberans (Compare with Figures 1-d and 3-b). At this operation a Syme's Amputation of the left foot was also carried out for the eighth local recurrence of the primary lesion (See Figures 3-a, b).

Figure 3-a. Photograph of the left foot in the case herein reported in detail (Case 7, Table 1), following Syme's amputation done in concert with the right thoracotomy performed on June 6, 1972, showing the nodular, firm, reddish, primary tumor mass. The amputation was performed after the eighth recurrence of the primary tumor. The patient had consistently refused amputation prior to this and the lesion had been treated by multiple local excisions. Tumor involved the area from immediately beneath the epidermis on the dorsal surface to the subcutaneous tissue on the plantar surface of the foot.

3-b. Photomicrograph of section taken from the dorsal surface of the involved foot. The primary tumor (dermatofibrosarcoma protuberans) can be seen arising beneath the epithelial surface. Compare this histological picture with Figures 1-d and 2-d.

Histological examination of this second intrathoracic tumor mass once again revealed metastatic dermatofibrosarcoma protuberans (Figure 2-d). Although the amputated foot (Figure 3-a) was free of tumor at the line of resection, microscopic analysis revealed extensive infiltration from the dorsal surface to the subcutaneous tissue on the plantar surface (Figure 3-b). Further local excision at this time, instead of the amputation carried out, obviously would have been followed by yet another recurrence.

The patient convalesced from the thoracotomy and amputation without incident and at present is being followed as an outpatient at monthly intervals.

Comment

Dermatofibrosarcoma protuberans, a tumor with characteristics both of a fibroma and sarcoma,[4] was first described in 1924 by Darier and Ferrand,[1] who felt that it deserved consideration as a separate entity. Its present and most commonly used name, however, was not coined until one year later (1925) when Hoffman[3] reported three of his own cases.

Clinically, the tumor presents as a slow-growing, firm, reddish, cutaneous mass, usually on the trunk[5] with a tendency for recurrence following inadequate operative removal, but with rare evidence of metastases. An analysis of 86 cases in a recent report, revealed metastases in only five.[5]

Of the seven patients treated in our own institution (Table 1), six developed tumors on the trunk, five (Cases 2 to 6, Table 1) anteriorly and one posteriorly (Case 1, Table 1), while one (Case 7, Table 1) developed the lesion on the dorsum of the left foot, an uncommon location (Figure 4).

Although this tumor is most commonly seen in patients between the ages of 20 and 45,[2] they have occurred in patients of all ages. One of our patients (Case 1, Table 1) had her last resection at age 76.

The high recurrence rate of the primary lesion is related to extensive infiltration by the tumor into the underlying subcutaneous tissue planes, a fact which may not be appreciated by the operating surgeon at the time of initial excision. In our own series, multiple recurrences developed in three of the seven cases (Cases 1, 2 and 7, Table 1). In one case (Case 7, Table 1), adequate removal of the primary mass initially was prevented by the patient himself, who consis-

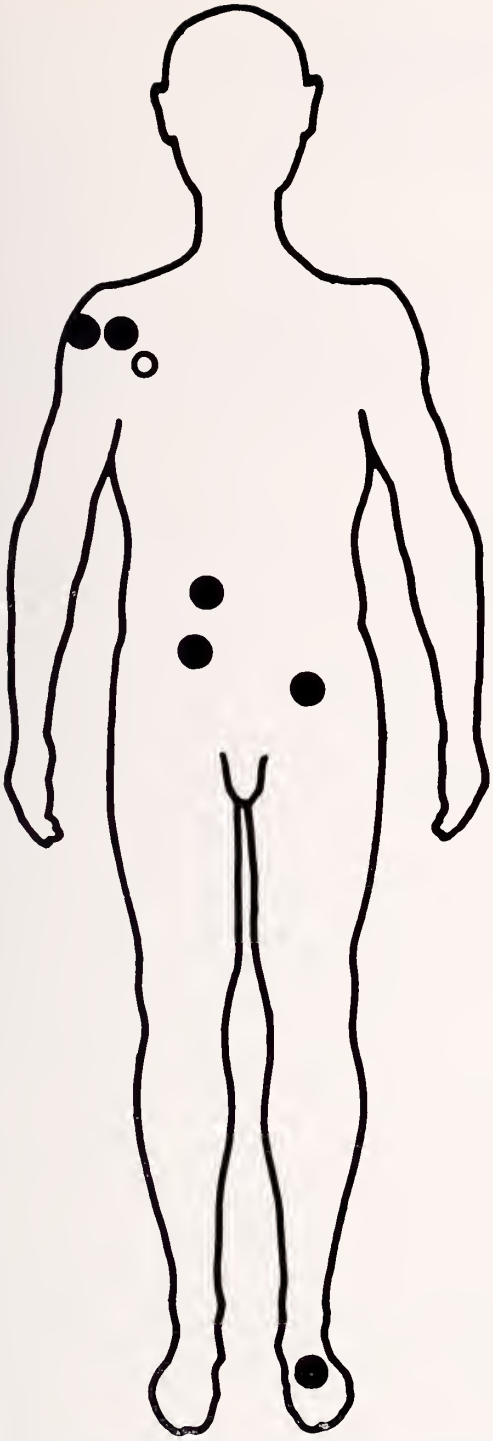

Figure 4. Line drawing illustrating the sites of the primary tumors (dermatofibrosarcoma protuberans) seen in seven cases at the West Virginia University Medical Center over a 12-year period (1960-1972). The majority (six) occurred on the trunk. Five of these (closed circles) presented as anterior tumors while one (open circle) presented on the posterior surface of the right shoulder. In one case the primary lesion developed on the dorsum of the left foot, an uncommon location.

tently refused amputation until metastatic disease occurred.

It has been felt by some that multiple inadequate excisions of the primary tumor mass predisposes to the development of metastases.[5] This impression would appear to be substantiated in the case detailed in this paper (Case 7, Table 1), as the patient had had six unsuccessful resections prior to the development of his first pulmonary metastasis.

Operative removal of the primary tumor is the treatment of choice. Adequate local excision has been defined by Pack[8] as a margin of four to six cm. of normal skin and subcutaneous tissue surrounding the gross margins of the lesion. Pack further states that excision should include the underlying superficial fascia even if uninvolved in an *en bloc* manner. It should be noted, however, that when the lesion is no longer resectable there is some evidence that chemotherapy utilizing Methotrexate may be helpful.[6]

Summary and Conclusions

A brief review of seven cases of dermatofibrosarcoma protuberans seen at the West Virginia University Medical Center over a 12-year period (1960-72) is presented.

Inadequate resection of the primary tumor at the initial operation resulted in local recurrences in three of our seven cases. In one of these, multiple (two) intrathoracic metastases (to the upper lobe of the right lung and the parietal pleural surface of the right hemithorax) developed after six local resections of the primary mass. These necessitated two thoracotomies two-and-a-half months apart for removal.

Adequate initial local excision of the primary tumor which includes *en bloc* resection of four to six cm. of normal skin and subcutaneous tissue surrounding the gross margins of the lesion, together with the underlying superficial fascia even if this is uninvolved, is the treatment of choice.

Although the tumor rarely metastasizes, the frightening aspect of its tendency for local recurrence because of inadequate initial excision is emphasized.

Addendum

The patient (Case 7) has been readmitted to this hospital with a third (unresectable) intrathoracic recurrence.

A list of references may be obtained by writing The Journal.

Women: Fitness and Fatigue*

Evalyn S. Gendel, M. D.

QUESTION: Does the chronically complaining, fatigued female contribute to the tension which affects the cardiovascular system both of males and females?

ANSWER: There hasn't been a great deal of research on this syndrome—especially in the case of the female.

The culture, which greatly influences medical practice, identifies quickly with the "man on the move" who becomes chronically tired, the athlete male or female who loses a particular competitive power because of cardiovascular or other disability, concern for the "middle years" of the family man, the top executive, the rising statesman.

Not so much identification exists (especially among male physicians) with the "tired housewife" (unless he has one), or the girl with menstrual cramps who often gets a medical excuse from P.E. quickly written, rather than a thorough pelvic examination, or the woman journalist, executive, designer who is concerned about her lack of energy.

This is not a renewal of the "battle of the sexes," but, rather, a statement of fact—quickly sensed by most male practitioners. When they think of physical exertion for their patients, whether as a health maintenance or a rehabilitative measure, their focus is on other men—in this case male patients. Only in the case of "superwoman" is there evidence of special concern.

Background—Superwoman and Women

The sociocultural mystique surrounding physical prowess in women is deeply imbedded in our society. It is reflected in the attitude of adulation for women in Olympic competition as well as those outstanding athletes in golf, tennis and other special sports events. The psyches, menstrual cycles, fitness and histories of such women have been avidly studied and reported.[1, 2]

Simultaneously, the general public, the educational system and medical science have been largely indifferent to the general physical fitness or performance of the non-athletic woman, the "ordinary female" in the population. Physical education, intramural sports and competitive athletics in the public schools, relegate girls' activities in these fields to perhaps one full year during secondary education. Little or no encouragement into carry-over individual sports or to group activities and team sports is given. Whatever is arranged must be sandwiched in for those days when the boys can spare the space (obviously, not all school systems follow this pattern, but this describes the prevailing course of action).

Many groups are attempting to provide change,[3] but are faced with other "hangovers" from the past. The public, as well as girls themselves, echo the myths about athletic women as being "too masculine" (skaters, swimmers?) about "femine biological" differences and about the advisability of competition.[4] These attitudes are not compatible with scientific information on the subject, and persist in centering around the superwoman and her activities (Olympics, national tournaments). These concepts have provided the initial evidence of the need for study of the "common woman."

In a paper presented before the 1965 Conference on Medical Aspects of Sports,[5] the author reported on 100 patients in her private practice (ages 18-23) who complained of chronic low backache and fatigue, following pregnancy. After eliminating orthopedic, pelvic, renal and psychological causative factors, 35 patients remained, who had several positive findings in common: a history of lack of regular physical activity since early childhood, poorly developed anterior abdominal musculature, and long-term, post-delivery, chronic complaints, which resulted in poor functioning as wives and mothers. Over a period of six to ten months of gradual physical conditioning on an individually perscribed and demonstrated basis, there was steady improvement and reduction of symptoms. This small

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*Presented at a meeting of the West Virginia Academy of Family Practice on April 21, 1972, in Charleston.

study as well as interviews of 50 female high school students, at random (who had never delivered a baby) about their physical activity, with over half showing histories of lack of physical exertion, led to speculation about the effects of fitness on chronic disability in the general population of young women.

Has medicine contributed to the folklore about women and physical exertion? Have the studies on pregnancy outcome, dysmenorrhea, been confined primarily to the woman in competition?

Having been trained as an orthopedic surgeon, but moving into general practice for several years, I became aware of the results of this general attitude in the study just described and undertook, in 1968, to review a larger sample of young women, college age, who had never been pregnant, to determine whether or not lack of physical exertion since early childhood had any impact on the current physical daily functioning of this population.

Without reviewing the entire research project, let me outline for you some basic approaches which augment an analysis of the patient's condition in almost any circumstance and which I believe is applicable both to male and female (except for the menstrual history).

Several "histories" are employed:

Regular Medical History.—including all systems. Permission to review college entrance examinations (all subjects were college freshmen) gave added depth to this section.

A 1-5 scale was applied to this examination.

1. Generally normal.
2. Moderate history of incapacitating history.
3. Mildly incapacitating history.
4. Abnormal incapacity.
5. Abnormal—severely incapacitating illness or disease.

Sex and Reproductive History.—including menstrual history. Besides a thorough menstrual review, and pregnancy history, a sex history is included as a basic part of the total medical history.

A 1-5 rating, again in general terms for the study, were given.

Physical Activity History.—current and past.

Also, a 1-5 rating.

1. Extremely active and competitive.
2. More active than her peers.
3. Fairly active (considers herself average).
4. Seldom active.
5. Lies down when activity is mentioned.

(The questions in each of these are shown.)

Medical Complaint History.—Personnel in the student health service, faculty students themselves remarked about the high chronicity low pathology complaints of many women students—which inspired this segment of the pattern of examination. A rating scale of 1-11 was given ranging from no complaints to extremely severe complaints. Within this category the most common concerns listed in the student health service were chosen: low backache, menstrual problems, headache, digestive disorders, fatigue colds, upper respiratory problems and allergy.

Physical Examination.—A general physical examination, including a pelvic examination and thorough orthopedic review was performed.

Releases for the pelvic were obtained and every girl received a pap smear.

No x-ray survey was used except in two cases.

The medical findings were rated on a 1-5 scale to parallel the history findings regardless of the pathology: from no severe abnormalities, generally normal—to—abnormal physical findings, severely incapacitating.

Physical Fitness Tests.—Physiological testing—a cardiorespiratory efficiency test using a bicycle ergometer.

Measurements taken were: (1) work capacity, (2) oxygen utilization at submaximal and maximal conditions, (3) heart rate at submaximal and maximal conditions, (4) blood pressure at these conditions, and (5) respiratory rate at these conditions.

Physical fitness data ratings were given and were part of the total data which encompassed 44 parameters on 67 subjects which were computerized for means, standard deviations and intercorrelations—using a General Electric 625 computer.

Strengths and Weaknesses of the Study

Strengths.—(1) Provision of a physical examination with pelvic and orthopedic special dimensions established a more comprehensive baseline of information. Documented factors about the medical and physical condition of the subjects, undertaken by the same examining physician, provides one more facet of measureable data to be added to the physiological measurements and historical input. Speculation on the medical status of subjects has been a more frequent element in many previous studies. Detailed medical evaluation for existing causation of disability, if any, was not found, and at the same time, could not be ruled out of such studies.

Each subject was seen by the same consultant personnel, so that fairly consistent input of data was possible. Ratings were made from a same judgment baseline, rather than mixed interpretation which accrues when multiple examiners are utilized.

(2) The subjects were not members of competitive teams or special athletic endeavors, and in this sense represented, at least for their middle class sample, a unique group for study. Previous studies have been primarily focused on the female athlete and the generalizations resulting have been applied to a non-athletic population, when they have been considered at all.

(3) Inclusion of a few married and previously pregnant women of the same age group provided data which can be analyzed further, which tie closely to the study by the author in 1965, and which mandate further research into the implication for pregnancy performance and complications of pregnancy. Negative attitude changes in women toward their own female functioning, lasting the rest of their adult years, have frequently developed following pregnancy when vague symptoms ensue which are permitted to become chronic disabilities without adequate epidemiological study.

Weaknesses.—(1) A larger sample would have been preferable, since the subjects were, of necessity, self-selected (they had to provide permission and other considerations for examination and review of records before they participated). Up to 200 subjects were originally anticipated, and could easily have been obtained. Over 100 volunteered after only brief announcements in residence halls and dormitories, and a call for more would have been met.

(2) The time needed for each total examination resulted in schedule problems and deadlines for research personnel which reduced the total sample to 67 subjects (all personnel, graduate student coordinator, physiology laboratory technicians, registered nurse, consultant physiologist and examining physician, provided their services and facilities on their own time). The total period for interviewing, physical examination and fitness testing amounted to approximately one and one-half to two hours for each subject, involving close to 50 man hours per subject for each consultant. Students were scheduled on an individual appointment basis so that, with cancellations, rescheduling, and the like, the periods of "free time" for all, literally ran out.

(3) The homogeneity of the students themselves was considered a limitation for two reasons: (a) The girls from moderately affluent families represented a group who had had access to instruction in tennis, swimming, dancing and whose value systems included at least some emphasis on fitness, making them less typical than more varied groups; and (b) The backgrounds of the population represented are almost similar, and do not provide conclusions which are applicable to as broad a spectrum of the population of young women as would be seen in those from differing social, ethnic and economic backgrounds.

Results of the Study.—Correlates of 44 items on 67 subjects produced voluminous data for interpretation. Means and standard deviations for all parameters are contained in detailed data sheets by the authors, but are not included in this paper. The significant medical implications are discussed, first as generalizations applied to the total group, and then more specifically to characteristics of subgroups.

General Results for the Group.—Subjects were slightly more active than the average American young woman. None could be classified as sedentary and none could be classified as athletes or as extremely active.

Most of the subjects had been exposed to only one and three-tenths years of physical education during senior high school.

Although many of the subjects were rated as fairly active, they were not shown to perform strenuous activity which taxes the cardiovascular system.

The most common complaint was menstrual difficulty, with colds and allergies the next most frequent.

Fatigue and headache were the complaint areas with the next highest mean.

A history of menstrual discomfort was also most common in the *medical records*, whereas abnormal findings on pelvic examination and in aberrations of menstrual schedule were not so universal.

In the small group who had ever delivered a baby, there were less menstrual complaints by a high degree, than with any segment of the never pregnant group.

The married, never pregnant group showed a higher degree of chronic backache, poor abdominal strength and relaxed muscle tone, even though their prior activity histories through high school were similar to the total group.

None of the subjects in the study was rated by the physician as obese, and the taller, heavier women scored highest on physiological fitness.

The group which were rated most active were also the subjects who were able to score highest on modified pushups.

The correlation of complaints of fatigue with physical activity were less in the group rated as currently physically active.

Those who scored highest on work capacity and were rated physiologically fit on all parameters, had a high correlation for less complaints of colds, allergies, digestive disorders and fatigue.

The subjects with maximal high heart rates in the work tests, scored low on physiological fitness and tended to have the highest rate of backache complaints.

There were high correlations between those subjects whose orthopedic examination showed spinal motion limitation and poor posture, with complaints of backache and with negative histories of past and current regular physical exertion.

There were positive correlations between general health ratings on medical history and increased complaints of menstrual problems, even though, on examination, the subject's pelvic findings and menstrual schedule were not unusual.

Comparison of Two Levels of Fitness.—Comparisons were made between the group of subjects who scored below the means and standard deviations on physiological fitness (46 subjects) and those who scored above (21 subjects).

The means for height, weight and body type were less for the women at the lower level of the physiological fitness scale. The same group also showed a lower mean for years spent in vigorious physical activity in high school.

The subjects on the higher level of the fitness scale were able to work one minute longer than the lower group, and this correlated closely with a maximal heart rate mean of 182.86 for the higher group and 198.26 for the lower group. There was less taxing of the cardiovascular system for the group rated highest in physiological fitness, even though the work performed was sustained for one minute longer.

As in the general conclusions, the more physiologically fit group had less of all of the common complaints, menstrual discomfort, backache, digestive disorders, fatigue, colds, allergies, except headache. The parameters for this complaint were comparable in both groups.

In the low fitness group, weight in pounds had a negative correlation with work capacity, decreasing the ability to perform. In the high fitness group, weight in pounds had a positive correlation with work capacity, increasing the ability to perform.

(Speculation from these opposite correlations led the observers to believe that adipose tissue made up the weight in the low fitness group, whereas muscle mass may have provided the weight in the high fitness group).

Interpretation and Significance of Conclusions.—The eight subjects (or 11 per cent) in the study who had experienced pregnancy and delivery showed, even with histories of moderate physical activity in the past, the highest correlation of decreased abdominal muscle tone, backache and fatigue. Among the remaining subjects with milder complaints, the stress of pregnancy could make them future candidates for similar difficulty. Pregnancy and delivery epitomize all of the elements of the most strenuous work capacity tests which can be given, especially if women were encouraged to participate in it. In general, girls and women are not prepared for this task, and many are asleep or heavily sedated while it is occurring. "Crash" exercise programs *during* pregnancy cannot substitute for long-term involvement in regular physical exertion. In the best prenatal programs, unfortunately, exercises in preparation for childbirth are not always routinely recommended. In a review of the literature, one author indicates that women athletes have less Cesarean sections than the general population and less complicated deliveries;[6] whereas Pouret, in his studies, has indicated increased complications. Although both studies were undertaken on women in competitive athletics, whose fitness was expected to be excellent, control studies on the "common woman" are needed.

Overwhelmingly, however, the literature on menstruation indicates routine strenuous activity on a continuing basis, decreases chronic dysmennorhea, except where pelvic pathology is the causative factor.

The significant factor is that in this youthful group of 67 generally healthy female subjects (with or without the inclusion of the subjects who had been pregnant) none of them exhibited superior fitness scores, or long-term histories of regular strenuous physical exertion. The range of work efficiency, while generally fair, was not exceptional in either direction, very high or very low. Almost 100 per cent of the group had menstrual complaints and mild disability, but there were only a few physical findings to substantiate the universality of the chronic complaints. If this much chronic symptomatology exists, at a time when physical activity for most women is decreasing, the pool of women whose

future pregnancies could precipitate further disability is startling!

I have chosen to emphasize this one factor of pregnancy performance because it is dramatic, and because the majority of women expect to become pregnant sometime in their lives. Would there be a difference in the quality of their lives and that of their offspring if women were encouraged to physically be prepared to participate in the birth process? Those who have been actively involved in "prepared childbirth" provide excellent evidence of this need.

Chronic menstrual discomfort, largely accepted by women as "normal," provides excess days of absenteeism from work and school, and modification of participation in many other activities. The understanding of this normal physiological event by most women is poor, leading to negative expectations which accentuate the problems. Women, themselves, perpetuate the mythology; and physicians, most often male, are affected by their complaints and legitimize them. Industry provides "sick days" which women employees expect to take during their menstrual period. Medical excuses from physical exercises, swimming and other activities for girls often are written by the physician solely at the request of a patient who says she has trouble. In this study, only two of the subjects who had experienced the most severe complaints had been examined by their doctor. The others, though showing a history of problems on their charts, had a notation by the physician that a pelvic was not indicated. Thirty others, with similarly severe disability, stated that the physician simply ignored their symptoms and told them they would improve as they got older.

In reviewing the college entrance medical examination on all subjects in the study, only three of them had been given a pelvic examination as part of the routine physical. The reluctance or ignorance of the patient to request this examination may be explainable, but the physician's omission of this routine part of a thorough physical is not. Discussion of this issue with patients over the years, indicates that the importance of a pelvic examination often is never emphasized by their physician. The inadequacy of such a physical can be compared to omitting the rectal examination in any complete physical, male or female.

A patient's indifference or fear of this element of her physical evaluation is responsible today for many young women accepting "cramps" and disability in menses as "her lot," and for women in general to wait for symptoms before reporting for this examination, usually when it is too late.

This aspect of the study, not included in the computerized data, offers a perspective on patient and physician education which needs to be stressed.

The subjects who scored well on the physical fitness tests generally had fewer complaints in all categories, and indicated little disability. The fact that colds and allergy were less in this group substantiates previous references to physiological fitness as a possible basic preventive factor in common virus illnesses.[7]

This ties in closely with the negative correlations of digestive, fatigue, colds and allergy complaints with maximal oxygen utilization, and is an excellent indication that the maximal rate at which oxygen can be utilized is an important measure of the ability of the circulatory and respiratory systems to meet the demands placed on them by vigorous physical activity, and to provide an efficiency (perhaps) in mobilization against infection, simply moving the viruses "out" before they have a chance to "move in."

The conclusion that none of the subjects was rated as extremely active and athletic, or as sedentary, and scored in a range between seldom active and moderately active (slightly more than scores for the average, active American female), has serious implications on the relation of disability to fitness. Forty-six of the subjects scored low on physiological fitness and high on moderate disability and even higher on the number of chronic complaints. Yet none of the subjects exhibited physical findings severe enough to account for their complaints. In other words, the lack of fitness alone can be the only problem, and one that is *infrequently diagnosed and seldom given therapeutic attention.* Simply encouraging patients and the public to "be fit" does not provide enough understanding of fitness as a factor in medical disability. Educators and physicians alike should note that in the low fitness group (46 subjects) 15 had no high school physical activity on a regular basis, 28 had up to one year in high school and the remainder had more than a year (24).

The girls who had the highest degree of arm and shoulder strength had less disability related to backache. Since strength in these areas can be developed only in certain vigorous activities, very few of the group scored well. In a previous case review by the author of adolescent scoliosis[8] and results following bracing, or casts, the more active group had the least complications. The girls who had been most active in sports (tennis, tumbling, swimming, and who continued this activity, even modified, while in treatment and

through their rapid growth period, had corrections of spinal curvature which were most successful. The maintenance of muscle integrity in other conditions also must be significant.

The findings related to poor posture as a common denominator for many of the low score parameters are to be expected. A definition of poor posture, however, is subject to so much interpretation, that it was recorded in the study primarily under the general orthopedic evaluation.

Individual severe pathology was found in only two subjects, one in which a spondylolisthesis had resulted in a spinal fusion, lumbar two to five, but which had not caused limitation of the patient's activity since recovery from surgery four years previously. She was active in swimming and golf and scored well on her work performance and physiological tests. Another subject had undergone considerable discomfort and disability for chronic pain and limitation of motion in her left hip. Surprisingly, she had never had a complete orthopedic evaluation. She was one of the few referrals for x-ray examination and for possible orthopedic treatment. These could not be undertaken within the scope of the study.

The general good health observed in the physical examinations of the subjects was not reflected in the subjective complaints and claimed disability. Part of the problem has been alluded to in the lack of knowledge of women about their own normal functioning and the mystique which has developed around it in medical and educational fields. The psychological implications are directly related to the sociocultural acceptance of poor expectations about menstruation and to the common fantasies of the biological "female" role. Although this was not a specific parameter of the study, it became strongly evident in the course of interviews with the subjects, while they were being examined, and in the orientation needed before a pelvic examination could be undertaken.

Educational implications were also reflected in the surprising basic ignorance the subjects had about their own anatomy. Fifty per cent of the subjects were completely misinformed about the use of tampons in virgins and about the geography of the vaginal opening and the hymeneal ring specifically. The attitude and behavior which develop around such minor basic facts and many others, are reflected in the lack of confidence which many young women exhibit about their ability to participate in sports and vigorous activity during menstruation, and are repeatedly seen in more distressing apprehension and anxiety in marriage, at a later date.

The educational and psychological factors briefly reported here were inherent in the study and are incorporated in the recommendations.

The choice of timed, sustained leg lifts in the testing for abdominal strength was based on the tests's efficacy in eliciting abdominus rectus fascial defects, which can be palpated when the patient raises and lowers her legs. Telemetry was not used to measure muscle capability or to be tested against the "truck roll."

Comment and Recommendations

The tired, complaining cross female companion, date, wife, daughter, boss, or friend, is no joy to anyone. If her problem is based on disability and medical incapacity, hopefully, she can be cured. If, however, no diagnosed clinical condition exists, and she appears "normal" then we must, as physicians, develop a higher index of suspicion about her physical fitness, which will enable us to include at least a history of physical activity, current and past, and a simple test of vital signs after exertion and rest in our evaluation of chronic, vague complaints.

We need a more comprehensive program of education about normal human growth and development for students at all levels, and for the public at large to help them understand better the normal, physiological functioning of both sexes. Menstruation and childbirth are only two processes which affect women directly and men not so indirectly, which are still steeped in ignorance. The women in the society, in turn, influence the professional judgment of men in the medical, educational and even legal fields by unconsciously capitalizing on the fact that they are experiencing the function, and that scientific knowledge "doesn't count." Dissolution of the obstacles to communication which have developed by these directions can be best accomplished through education.

Although we won't be waiting for it, once the rosy dawn of enlightenment occurs universally, we are then faced with providing motivation to overcome superstition and physical inactivity. This will take the continuing efforts of those educators who are already urging better programs for children in their early school years, which help them to appreciate their physical ability and to enjoy physical exertion, which will result in carry-over involvement throughout their lives. Many new people will need to take a stand. Those physicians who recognize the measureable preventive benefits and the medical relation between fitness and health, will have to become

more vocal about it to their colleagues, to their patients, and to the public. Conditioning for life "work loads" should become as important as the conditioning we insist upon for our trained athletes and for the commercial censures of professional athletics and for Olympic competition.

Attention to fitness for increased numbers of girls and women will require upgrading in facilities and equipment available to women. It means removing girls' and women's competitive programs from the realm of "outside" activity to the area of the regular school environment. Why should girls in track and swim competition be only those who come in contact with the interested coach or physician who will undertake a special extracurricular program for them? They become "federal cases" because they are not part of the school systems' program, and only a few are exposed. A concerted effort must be made for a continuing sequential, energetic program from primary grades through college. The result of this effort could produce a reserve group of interested, skillful, motivated women who would be available to competitive athletics, to Olympic criteria, but the effort would benefit all women, athletes or not.

Women are increasingly being urged to utilize their full potential as human beings, in a world that needs all humaneness it can muster. Women will need all the energy and well being they can get if they are to do this. The role of pregnancy and childbirth is an important facet of this mandate, and should not be the point at which chronic disability, real or imagined, becomes an obstacle to their own and their families' development.

The "battle of the sexes" often is injected at some point into the considerations of the enhanced roles of either sex. I advise my own patients, male or female, to adopt the attitude in this artificial "battle" that it is fun to win, and just as much fun to lose. There is no real "battle" over the need for personal communication and mutual growth.

Continued comprehensive research into the relations discussed in this paper are needed for study of broader, more varied segments of the population. The cost of chronic disability cannot be cost accounted in the losses which occur in work, in family disruption, in human suffering, but they are great. Unless such data can be made known and available to the population at large, we are likely to increase the problem as we move more rapidly into a spectator society.

Special Note

The project described in this paper was conducted cooperatively, without expenditure of grant funds, or any other funding. The study covered a period of 20 weeks of active involvement, and nearly a year of planning. The coordinator working on her master's thesis, the examining physician, obstetrical nurse, physiologist, laboratory technicians and students worked during their own free time in addition to conducting full-time duties in their own jobs. The examining rooms were made available by the Student Health Service; equipment, instruments and disposable gear were furnished by a surgical manufacturing supply firm and a group practice medical clinic. Computer services were loaned, without charge. The interest in the project exhibited by this group, the right combination of time and people, inhibited application for a grant. Although advised to apply for funds, fear of delay in initiating the procedure discouraged it.

A list of references may be obtained by writing The Journal.

Sports Medicine

SPORTS medicine used to consist largely of a trainer with a bottle of linament and some tape. No more. It has reached the point where an Institute of Sports Medicine and Athletic Trauma has been opened, at Lenox Hill Hospital in New York City.

There are about eight million injuries each year in sports, says the Institute's director, Dr. James A. Nicholas. And although there are many programs concerned with sports medicine, there is little coordination or research, Doctor Nicholas said. The Institute hopefully will provide that.

Dr. Nicholas is well-qualified in the field—he is team physician for the New York Jets and the man of the knocked-about knees, quarterback Joe Namath.

Peripheral Venous Diseases*

Jess R. Young, M. D.

The disorder of varicose veins is one of the most common affecting man. This condition is probably the result of a congenital weakness of the venous walls and the valves. The incidence is higher in women than in men. Obesity, pregnancy, prolonged standing and thrombosis of the deep veins are important contributing factors.

Clinical Picture

The most common symtoms are those of aching, fullness or fatigue on standing which is relieved by recumbency or by the wearing of an elastic stocking. It is important in the diagnosis to exclude other conditions such as tension fibrositis, water-retention syndrome, osteoarthritis, or a disk that may be causing symptoms in a patient with varicose veins, for even severe varicosities may be relatively symptomless.

Superficial thrombophlebitis and external hemorrhage are possible complications of varicosities. When severe varicose veins have been present for years chronic stasis changes may appear with pigmentation, fibrosis, dermatitis and ulcerations.

Treatment

The aim of medical therapy is chiefly to relieve symptoms and to try to prevent the progression of varicose veins. All patients with varicosities should wear elastic stockings, exercise their legs, keep their weight at an ideal level and, when possible, sit with their legs elevated. They should avoid wearing tight clothing such as garters and panty girdles, and should avoid prolonged standing. It may be helpful to elevate the foot of the bed between four and six inches to decrease venous pressure while sleeping.

When varicosities are small and the patient wishes treatment for cosmetic reasons, injections of sclerosing solutions may be attempted. For more advanced varicosities, the patient either should wear elastic stockings or else should undergo surgical removal of the affected veins by ligation and stripping. Any varices not removed by these procedures subsequently may be injected with sclerosing solutions as an office procedure.

*Provided by the West Virginia Heart Association.

The Author

- **Jess R. Young, M. D., Department of Peripheral Vascular Disease, The Cleveland Clinic Foundation, Cleveland, Ohio.**

Superficial Thrombophlebitis
General Comments

Thrombophlebitis in one of the superficial veins may be caused by trauma, intravenous ininjections or may be associated with certain systemic diseases such as blood dyscrasias. Recurrent superficial phlebitis may be the first manifestation of thromboangiitis obliterans or of an occult malignancy, or may occur for no apparent reason.

Clinical Picture

Superficial phlebitis usually presents as a red, warm, painful, tender nodular area directly under the skin along the course of a vein. Edema is not present. The clot is adherent and is rarely the source of emboli.

Erythema nodosum may be quite difficult to differentiate from superficial phlebitis, and a biopsy may be necessary. Cellulitis should present no problem in differential diagnosis, for the process is more diffuse and there is no palpable cord along the course of the vein. Lymphangitis likewise should present no problem in diagnosis, for again no thrombosed vein is palpable and lymphangitis is associated with chills and a high fever.

Treatment

Most patients with superficial phlebitis need nothing more than rest and elevation of the extremity and application of warm, moist packs for a few days. When the pain and inflammatory reaction are severe, phenylbutazone or oxyphenbutazone may be given for three or four days. When the phlebitis continues to extend despite treatment, anticoagulation therapy should be initiated.

Deep Thrombophlebitis: General Comments

Deep thrombophlebitis is still one of the more common complications of major surgical operations, pregnancies, fractures or injuries of the

lower extremity, or any serious illness that requires the patient to be confined to bed. The increased incidence with congestive heart failure, polycythemia, ulcerative colitis and carcinomatosis is well known. In many instances, deep thrombophlebitis occurs for no known reason.

Clinical Picture

Early venous thrombosis may not be recognized clinically because of the absence of local or constitutional signs. The first indication of its presence may unfortunately be the occurrence of pulmonary embolism. However this asymptomatic bland type of venous thrombosis (phlebothrombosis) usually progresses to the more inflammatory state of thrombophlebitis which can be diagnosed clinically.

In the majority of patients the onset of deep phlebitis is gradual and mild, and the symptoms are often mistaken for rheumatism or muscle cramps. The discomfort is described as a dull ache in the calf or in the region of the thigh which is worse on standing, but relieved by recumbency.

The findings in deep phlebitis include edema, distended superficial veins, localized tenderness in the calf region or over the femoral vein, and the presence of Homans' sign with pain in the calf region on dorsiflexion of the foot with the knee in flexion. Usually, only minimal systemic reaction accompanies deep venous thrombosis. A low-grade fever, slight tachycardia, malaise or a sense of apprehension may be present.

Various methods have been proposed to detect intravenous thrombi, including the use of radioisotopes, ultrasonic flow detection studies and measurement of electrical impedance. Although these tests hold great promise, venography remains the most definitive method of study and should be done when the diagnosis is in doubt.

Treatment

Because of the constant threat of pulmonary embolus, anticoagulant therapy with heparin should be started as soon as venous thrombosis has been diagnosed. Heparin is injected intravenously in doses of 5,000 units every four to six hours, or subcutaneously in doses of 10,000 to 15,000 units every 8 to 12 hours. If the diagnosis is in doubt, heparin should be given prophylactically, unless contraindicated, until venography is performed and the issue is settled.

Ligation or clipping of the inferior vena cava is performed in the patient in whom heparin is contraindicated, and in the patient in whom pulmonary embolus develops while he is on anticoagulant therapy.

The patient with deep phlebitis should be kept in bed with his extremity elevated and, if arterial pulses are present, treated with warm, moist packs. After from four to seven days, the tenderness usually subsides and the patient may begin to ambulate. Then, the dosage of heparin is tapered and stopped. When significant edema persists, a well-fitted elastic stocking should be worn until such time that edema no longer appears when the stocking is not worn.

Venous thrombectomy may be considered in massive venous thrombosis, particularly in young, otherwise healthy patients.

Preventive measures against thrombophlebitis include early ambulation after operation, routine wearing of light elastic stockings by patients confined to bed, elevation of the foot of the bed, close attention to fluid balance to prevent dehydration, encouragement of active and passive muscle exercises, and avoidance of tight abdominal dressings.

Chronic Venous Insufficiency
General Comments and Clinical Picture

After deep phlebitis, the occluded vein usually becomes recanalized but the valves remain permanently damaged. If the patient does not properly care for his leg and wear a good elastic stocking to control edema, signs of chronic venous insufficiency may develop many months or years after the episode of thrombophlebitis. These changes include chronic edema, pigmentation, induration and dermatitis. After slight trauma, ulcers develop which may be extremely difficult to heal.

Treatment

If the patient is seen at a time when he has only edema and pigmentation, preventive measures should be advised to prevent the complications of dermatitis and ulcerations. He should sleep with the foot of his bed elevated on four to six inch blocks. He must wear a well-fitted elastic stocking when ambulatory. Exercises such as swimming, walking or bicycling should be encouraged, and prolonged standing or sitting should be avoided. Women should not wear panty girdles or garters.

If a small clean ulceration is present, a modified Unna paste boot is applied to the leg and changed at from 7 to 14 day intervals depending on the progress of the patient. During this period, he can carry on normal activities as long as his occupation does not entail prolonged

standing. Most ulcers will heal in from 4 to 12 weeks.

When the ulcer is badly infected with surrounding cellulitis, hospitalization may be necessary. The patient should be put to bed with the foot of the bed elevated, constant soaks applied to the extremity, and systemic antibiotics administered. When the ulcer is clean, the paste boot can be applied.

Very large ulcers will heal more rapidly and have a better chance of staying healed if a skin graft is used. It is important to do a wide excision and remove all the indurated area surrounding the ulcer.

Regardless of the method used in healing the ulcer, the patient must continue to wear elastic stockings and carry out the other prophylactic measures to avoid recurrance of the ulcer.

Summary

Varicose veins, venous thrombosis, and chronic venous insufficiency are common disorders affecting millions of people in this country. Numerous forms of therapy have been proposed. With newer methods of diagnosis of deep phlebitis and with improved evaluation of various types of treatment, perhaps some of the conflicting opinions regarding therapy can be resolved soon.

To Physicians in Training

To all physicians in training and especially West Virginia residents. West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual immediate attention.

Special Article

Medical Technology Education at West Virginia University

Betholene Frances Love

ADVANCES in medical knowledge and interest in health maintenance have brought about an exponential growth in the diversity and volume of laboratory procedures requested by the practicing physician. At one time the clinical pathologist could train laboratory technicians very adequately to perform the necessary techniques in hematology, chemistry, histopathology, blood banking and microbiology; but as the complexity of laboratory techniques increased and mechanization entered the clinical laboratory, it became necessary for laboratory personnel to be versed in the principles as well as the techniques of procedures, and formal educational programs became mandatory.

The profession of medical technology has evolved from the need for qualified personnel to staff clinical laboratories, and medical schools realize that they have an opportunity and perhaps an obligation to offer assistance in the education of these allied health professionals.

As early as 1945, the West Virginia University School of Medicine recognized the need for an educational program to provide qualified laboratory personnel for the State of West Virginia and inaugurated a program which 25 years ago was unique in that a B. S. degree was granted at the end of a four-year course.[1] Few colleges or universities offered programs in medical technology at that time since laboratory medicine had not reached its present level of importance in health maintenance and patient care.

Résumé of Types of Educational Programs

Emphasis upon utilization of laboratory services in the diagnosis and prevention of disease has resulted in a need for well-qualified laboratory personnel, and at the present time there are approximately 783 schools approved by the Council on Education of the American Medical Association in collaboration with the American Society of Clinical Pathologists and the American Society for Medical Technology for the education of medical laboratory technologists.[2] Seven of these approved schools are in West Virginia with a capacity for 88 students.

The Author

- **Betholene Frances Love, Professor, Division of Medical Technology, Department of Pathology, WVU Medical Center, Morgantown.**

"School" as defined by the approving agency refers to 12 months of training in a hospital laboratory. In all schools, except a few which have special approval, 90 semester hours of college work to include courses in biological science, chemistry and mathematics are required prior to entry. The curriculum for the approved school includes the basic principles commonly utilized in diagnostic laboratory tests, and technical instruction which covers procedures in hematology, serology, clinical chemistry, microbiology and other topics with value to laboratory medicine. It is recommended by the approving agencies that the course of training be at least 12 months in duration and be uninterrupted by vacations or sick leave.

Approval of a "school" of medical technology by the Board of Schools (composed of representatives of the American Society for Medical Technology and the American Society of Clinical Pathologists) and, subsequently, by the Council on Medical Education of the American Medical Association, merely indicates that a training program meets certain minimal requirements as given in the "Essentials of an Acceptable School of Medical Technology."[3] Since these are minimal requirements, they permit great diversity in the curricula of approved schools and, as a result, education in medical technology varies considerably from one school to another. In general, however, schools can be divided into the following three groups:

1. *Two plus two programs* which require two years of study in a liberal arts program before beginning two years of professional study usually in a school of medicine or a school of allied health professions.

2. *Three plus one programs* which require three years of preparation for entry into a school usually hospital sponsored and which includes 12 months of study.

3. *Four plus one programs* which are hospital-based schools and which require a baccalaureate degree for entrance followed by the 12 months in the hospital school.

Program at West Virginia University

The medical technology program, established at West Virginia University in 1945, follows the pattern of two years in liberal arts education and two years in professional study. Students who enter the University with the intent to major in medical technology enroll in the College of Arts and Sciences. During the first and second years courses in the physical sciences such as inorganic chemistry, quantitative chemistry, organic chemistry, physics and mathematics are taken. Students also meet the major portion of the University's "Core Curriculum" requirement during their first two years of study. This includes a minimum of 12 semester hours in the humanities and 12 semester hours in social sciences.

After completion of the premedical technology years in the College of Arts and Sciences (64 semester hours), the student enters the professional phase of the curriculum. In the junior year, which is the first year of the professional program, instruction in medical sciences such as anatomy, physiology, biochemistry, parasitology and microbiology is received. The student is introduced to clinical laboratory procedures also at this time. He learns to do finger sticks and venipunctures as well as manual methods in clinical chemistry, microbiology, immunohematology and clinical microscopy.

The senior year in college for the medical technology student at West Virginia University is the application of knowledge accumulated during the previous three years to the practice of the profession. Instructors of the senior year are, for the most part, the chief medical technologists who supervise the various areas of the clinical laboratories in the University Hospital. The curriculum of the senior year includes courses of study in clinical microbiology, immunohematology and blood banking, instrumentation, clinical chemistry, laboratory management, clinical microscopy, clinical histopathology, clinical hematology and clinical serology.

Throughout the two years of professional education, the student is instructed in medical ethics and motivated to become involved in the care of the sick by attendance at seminars and conferences. The philosophy of the program is that we cannot possibly teach everything there is to know about the modern laboratory, but we can supply our students with basic information, stimulate them to think, and give them ideals by which to live.

The courses in instrumentation and laboratory management have been renovated during the last two years to make them current with changes in the clinical laboratory. For example, mechanization in the laboratory has necessitated that the medical technologist receive an introduction to electronics and instruction in the use and care of laboratory instruments. Likewise, the increase in the volume of tests, introduction of computers, and involvement in budgets have resulted in the need for the medical technologist to have expertise in managing a laboratory. Course content of all courses in the professional curriculum is reviewed each year and innovations made when the instructors feel this is predicated by current needs in the clinical laboratory.

Scope of the University Program

The primary aim of the Medical Technology Division at West Virginia University is to provide a strong undergraduate program which meets the academic standards of the University and which provides an educational background acceptable for graduate work in the basic medical sciences. Since 1947, 324 individuals have been awarded the bachelor of science degree in medical technology. Two hundred and sixty-six (82 per cent) of the graduates have been West Virginia residents and, as a result, many stay in West Virginia after graduation where they are employed as technologists in hospitals, industry, public health laboratories, veterinary science and agriculture; as research assistants in medical

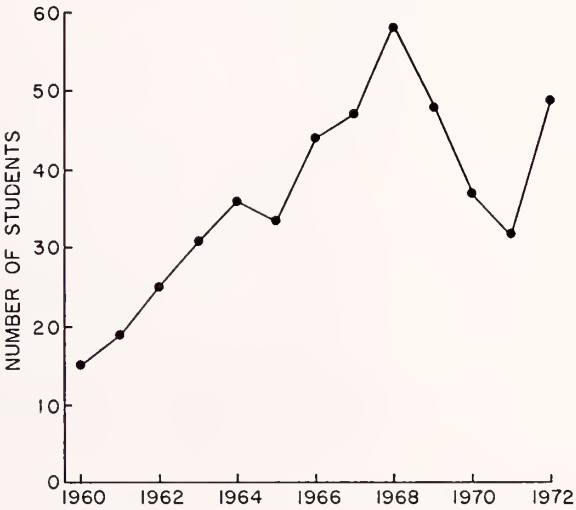

Figure 1. Students enrolled in the professional phase of medical technology at West Virginia University.

sciences; as salesmen for pharmaceutical companies and as teachers in medical technology programs in hospitals, junior colleges, universities and medical schools.

The number of students in the program has increased since the opening of the University Hospital (Figure 1). A recent study shows that a majority of the graduates are satisfied with the education received at West Virginia University.[4] Thirty-two (10 per cent) of the graduates have continued their education beyond the baccalaureate degree; for example, seven are now enrolled in medical school.

In the past, when medical technologists desired advanced education, it was necessary that they specialize in a particular phase of medical technology, and as a result many became lost to the profession of medical technology. To alleviate the shortage of medical technology educators, supervisors, and administrators a graduate program leading to the M. S. degree was begun in 1965. Twenty-eight students have been enrolled in this program so far, and the advanced degree has been awarded to 13 medical technologists. These graduates are now teachers, supervisors and administrators in programs of medical technology at West Virginia University and other institutions.

Summary

The role of the medical technologist has evolved from that of a laboratory technician who was primarily concerned with the performance of techniques in the laboratory, to a specialty which requires an individual who "analyzes problems and decides on a course of action based on what he knows about principles and theories."[5] The educational program in medical technology at West Virginia University has developed to meet the needs of the modern clinical laboratory and the changes in the role of the medical technologist.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes... yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

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These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

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Contraindications: Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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With the means at hand drastically reduce the number deaths each year from uterine ncer, we have embarked on a tionwide, life-saving program. goal is a Pap test by 1976 for ery woman 20 years or older whom the test is applicable, d for younger women at risk. ambitious program, doctor, d one which can only be alized with your help.

We are faced with these cts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

WEST VIRGINIA DIVISION, INC.
325 Professional Building
Charleston, West Virginia

IIS SPACE CONTRIBUTED BY THE PUBLISHER AS A PUBLIC SERVICE

The President's Page

NATIONAL CONGRESS ON THE QUALITY OF LIFE II: THE MIDDLE YEARS

Mrs. Robert G. Janes, President
Woman's Auxiliary to the
West Virginia State Medical Association

THE Congress to improve the Quality of Life in the Middle Years was held March 7-9, 1973, at the Palmer House in Chicago. It was sponsored by the American Medical Association in cooperation with other voluntary, professional and governmental agencies. Emphasis was placed on emotional, mental and physical health of the middle years.

A program of outstanding speakers was highlighted by a keynote speech by Hugh Downs, noted writer, lecturer and teacher. Dr. Lee H. Salk, author of "*What Every Child Would Like His Parents To Know,*" gave a most informative talk, "Parenting—The Hope of the Future." Dr. William H. Masters and Mrs. Virginia E. Johnson spoke on "Human Sexuality" and led a very interesting question and answer period.

It is hoped that the Quality of Life Congresses will generate enthusiasm for efforts of the private and public sectors to promote "productivity, happiness and health in the middle years." Congress III on "Problems of the Aging" will be held in March, 1974.

"Pearls" from the Quality of Life II—"Middle Age-Prime Time Society"—"More people spend time finding a qualified mechanic for their car than help for their child." "A parent should create people in the world who have a capacity of love and respect the rights of others." "The older we get, the more like ourselves we become." "Compassion without competence produces quacks." "A good marriage depends more on being the right person than finding the right person."

By becoming more aware of the changes and needs in the middle years, perhaps we can all enrich our lives.

Marinell Janes

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EDITORIALS

'ACUPINCH'

In our scientific community "new" is the byword. From some of our newer scientists rediscovery of some old — and some not-so-old — truths come to light every now and then. And some of the rediscovered "old" is frequently viewed with suspicion such as formerly was reserved for the black-cat type of ideas.

One of the most widely discussed and viewed of the "old-new"— or "new-old," depending on your viewpoint — is acupuncture, which captures the imagination in several ways. It is among the oldest of ancient "cures"; it has a definite amount of superstition in its background of application; it has received much modern attention and use in a country whose intellectual and scientific doors have been closed to Western countries for almost three decades; and it emanates from China with whom we have unofficially been at war for most of that time.

But in spite of its unscientific background its consideration has stirred a tremendous amount of curiosity here beginning with the publication of James Reston's account of his appendectomy in China while there a scant two years ago for which his only anesthesia was acupuncture.

Now comes another rediscovery of the old by way of another columnist — Norton Mockridge — whose syndicated column comes out of New York, who gives a Laurel, Maryland reader credit for putting him onto "acupinch" as treatment for a widely occurring symptom for which numerous drugs have been recommended and marketed — night leg cramps. Since quinine and benadryl have been found effective in its prevention, the etiology of this annoying and sometimes quite painful symptom does not seem to have come under very wide study. Now comes "Acupinch." According to Mr. Mockridge's reader, sometime in 1972 Mr. Milton F. Allen of Decatur, Georgia put an ad in the Washington Star describing his method of treating leg cramps and inviting any and all who would do so to let him know how it worked for them. Mr. Allen's treatment was described by him thus:

> *"At the first sign or notice of a leg muscle spasm — upon change of position, or waking up and stretching, etc. — immediately compress the facial area above the upper lip next to the nose by a sustained broad pinch (not painful). For best results, apply this surface pinch promptly with the ball or side of the thumb and the side of the bent forefinger for a few moments."*

According to this scientist the returned reports indicated a 90 per cent effectiveness for this method of aborting annoying and sometimes painful night leg cramps resulting in who knows how many additional hours of sleep gained by its practice. Now the thing that caught this writer's attention was Mr. Mockridge's comment that, according to Mr. Allen, "Doctors are not at all enthusiastic about Allen's 'acupinch.' In fact, they really don't want to hear about it." But, the columnist reports, the American Red Cross didn't give Mr. Allen the brush-off and in fact indicated considerable interest in the matter, particularly with reference to the more serious matter of muscle cramps as a factor in drowning

and the possible application of the principle through education and training in ARC's life-saving pursuits. Not so much for the saver, it is assumed, as for the savee to practice in the event of disabling cramps before he becomes so incapacitated as to drown.

The serious point of this commentary is that medical scientists might well beware of becoming so engrossed with highly technical scientific pursuits that they lose sight of the central aim of medicine — namely the relief of suffering through prevention and treatment. Perhaps the inclusion of some of the not-so-scientific remedies — old, new or old-new — in our scientific armamentarium of therapy will turn out to be the outstanding contribution of some of our colleagues during these days of change. Maybe acupuncture will turn out to be one of these — even if the physiologists and anatomists, gross and micro-, are unable to come up with a provable explanation for its effectiveness. And "acupinch" could be another.

To paraphrase a famous quotation, "When experts differ the public may choose." When doctors differ regarding nutritional needs, i.e. food requirements, vitamins, etc., the patient may choose.

WHAT'S FOR SUPPER!

Pity the poor patient who scans the best seller list and finds books telling him calories don't count, that he may eat all the fat he wants and no carbohydrates, or he may eat nine eggs and four grapefruits a day with proper nutritional balance; who for generations has been brainwashed to think that the American way is to eat all one wants, who is admonished by parents and grandparents to belong to the "clean plate club," who gets daily advice, solicited and unsolicited, since everyone is an expert on nutrition; who is regaled by full-size newspaper advertisements regarding the wonders of vitamin E, claiming it enhances longevity, prevents heart disease and rejuvenates sexual potency. Twentieth century shades of Ponce de Leon.

What is a person to eat when all of the basic food types, carbohydrate, protein and fat, have been found to have harmful effects in certain individuals. Everybody knows now that saturated fats produce high cholesterol or "greasy blood" which accelerates hardening of the arteries and contributes to the great American epidemic of arteriosclerosis. Almost everyone knows that protein rich foods increase purines and pyrimidines which are metabolized to uric acid which exacerbates gouty arthritis. Some of us know and more are learning that the basic carbohydrates like bread and potatoes can increase serum triglycerides in certain predisposed individuals and perhaps this too contributes to arteriosclerosis.

Consider liquid refreshment: what is a person to drink when milk and other dairy products are being assailed as contributory factors to hypercholesterolemia and hypertriglyceridemia. Coffee and tea are out because they are cortical stimulants, increase heart rate, blood pressure and stimulate catecholamine release. Carbonated beverages—never. These secret formulas probably contain an equivalent amount of caffeine as in coffee. Certainly no one wants to drink the polluted and chemically altered water from our superheated streams. And finally alcoholic beverages, thought for so many years to be harmless in moderation and perhaps even beneficial in terms of circulation and dietary stimulus. These are carbohydrates and fall right into the classification with bread and potatoes.

What's for supper? In today's vernacular, there "ain't no way."

Recently an article appeared in the *Journal of the American Medical Association* by Friedman[1] which reviewed the management of patients afflicted with migraine. This is an old theme,

MANAGEMENT OF MIGRAINE PATIENTS

but a critical review is always in order. He mentions that the exact site of origin of a migraine attack is not known, and emphasizes that the traditional view that migraine consists of phases of vasoconstriction and vasodilation is far too simple. He believes that migraine is a complex vasomotor disturbance, and points out that it is now recognized that three biochemical keys are in operation: (1) serotonin, a strong vasoconstrictor; (2) norepinephrine; and (3) bradykinin, a vasodilator.

One observation he makes, which probably will be questioned by some students of the subject, concerns the personality of the migraine patient, namely one who is tense, meticulous and obsessional. He feels that the significance of these personality traits have been overemphasized and are still open to question, and states that there are no published studies with control groups of similar age, sex and social and economic background. He makes no mention it is deemed by some that people with a superior intelligence and creative ability are more apt to suffer from migraine than those of lesser ability. It is conceded that this is a moot point and needs further study, because there are many individ-

uals of modest intelligence who too suffer from migraine.

As regards the diagnosis of migraine, Friedman points out that the physician must be aware of other disorders which may simulate this condition; among them are, intracranial tumor, amgioma, and hypertension. In long-standing headaches the matter of mental depression arises. One important point in establishing a diagnosis of migraine is a family history of periodic headaches. Friedman calls attention to what he terms "migraine equivalents." Among these he mentions: abdominal migraine, pains located in the thorax or pelvis, tachycardia, paroxysmal vertigo, and cyclical edea.

So far as treatment is concerned, he feels that for an acute attack of migraine, ergotamine with caffeine is extremely helpful to many people. He does not give the percentage of individuals benefitted by this therapy; the figure usually given is 80 per cent. He speaks of habituation to ergotamine; patients who take ergotamine daily in substantial dosage and who receive no benefit from this preparation may have an underlying mental depression which must be treated rather than just the headache. Friedman believes that individuals who suffer frequent acute attacks of migraine should presumably take some preparation daily in an attempt to abort the attacks. He recommends methysergide maleate in daily doses of from 2-6 milligrams; in his hands this treatment has been quite successful. In point of fact, this preparation has been a boon to many people. Attention should be called to the fact, however, that retroperitoneal fibrosis sometimes follows prolonged therapy with methysergide.

In the final analysis, so far as treatment is concerned, Friedman believes, in essence, that the selection of suitable therapy can only be made after a thorough medical, neurological and psychological assessment of the patient.

———

1. Friedman, A. P. Migraine Headache. J.A.M.A. 222: 1399 (Dec. 11) 1972.

1973 AMA-ERF Grants

U.S. medical schools are getting $963,823 in grants this year from the American Medical Association-Education and Research Foundation, according to Dr. Kenneth C. Sawyer of Denver, Foundation President. The AMA-ERF is funded by donations from doctors, and their wives through the AMA Woman's Auxiliary. Since 1951 when the program began, a total of $23,843,234 has been distributed to medical schools, Doctor Sawyer said.

Military Medicine: From Combat to Countryside

As the nation thankfully watches the Vietnam War fade into history, it is using one beneficial legacy of that war. And on some tomorrow, it might even save your life.

In Vietnam, speedy helicopter evacuation of the wounded—first started in Korea—was developed to a fine art. Men who would surely have died from serious wounds in earlier wars were saved in Vietnam. One estimate put the average time of evacuation at 17 minutes, from the instant a man was hit until he was under a doctor's care.

Watching this, medical and government authorities back home began wondering why the same thing couldn't be done here. Many Americans have died—and still die—because of traffic accidents on remote highways far from a hospital; or because the hospital they are taken to is not equipped for effective emergency care.

Now, the lessons of Vietnam are being applied; in the MAST program, for example. MAST stands for Military Assistance to Safety and Traffic, and provides military helicopters for transporting accident victims.

On request of a law enforcement officer in an area where MAST operates, a helicopter and trained medical aide will be sent to an emergency scene. There are about half a dozen MAST sites so far, in the West and Southwest, and hundreds of patients have been flown to medical aid.

The State of Illinois has pioneered a statewide "trauma network" program of emergency evacuation, using former medical corpsmen as coordinators. They get a description of a victim's injuries by radio and decide where the person should be taken. Someone with a spinal injury suffered in Southern Illinois, for example, may be airlifted hundreds of miles to a medical center in Chicago. The program has been credited with saving many lives.

Ex-military "medics" also formed the backbone of another new concept in civilian medicine—the physician's assistant. This is an aide who does much of the routine work—taking blood pressures, giving shots, etc.—and thus allows a physician to see more patients and spend more time with the more serious cases. Medics were ready-made for such a role, "having received several hundred hours of medical instruction at an estimated cost of up to $25,000," points out Dr. Walter C. Bornemeier of Chicago, former President of the American Medical Association. "Yet, previously, the only civilian medical career open to them was that of hospital orderly."

With the AMA playing a leading role in promoting use of physician's assistants, a number of training programs have been set up around the country.

But emergency evacuation and the physician's assistant program are not the only medical benefits that have accrued to civilians from military medicine. Many others are listed in a new pamphlet

issued by the U. S. Army Medical Department, *200 Years of Military Medicine.*

For example, another recent advance is a vaccine effective against Group C meningococcal meningitis, developed in 1970 at Walter Reed Army Institute of Research. The Institute is named for a military physician whose efforts at the turn of the century helped wipe out yellow fever.

Every time the TV weatherman tells you about the "wind chill factor" in Winter, you can thank military medicine. The Wind Chill Chart, based on work done in the Antarctic, was compiled by the Army in 1958 to provide information on the effects of low temperature and help reduce the incidence of cold injury.

In fact, speaking of weather, it was Surgeon General James Tilton in 1813 who directed hospital surgeons to report weather conditions daily, an action eventually leading to establishment of the U. S. Weather Bureau, the pamphlet says.

A century later, in 1913, Col. Edward B. Vedder's experiments in the Philippines demonstrated that eating unpolished rice could prevent the disease, beri beri.

Among the most dramatic, and valuable, research investigations by a military physician was that done by surgeon William Beaumont. In the late 1820s he actually observed the process of digestion—through a bullet-made "window" in the stomach of a young man named Alexis St. Martin; one of the most famous episodes of medicine.

Aside from research and development, military medicine's peacetime activities include helping in times of catastrophe, such as in the earthquakes in Anchorage, Alaska, and Managua, Nicaragua. Entire field hospitals and staffs of doctors and nurses are air-lifted to such disaster areas.

Established by the Continental Congress on July 27, 1775, "the Army Medical Department has played a vital role in the growth of and advancement of medicine around the world," Lt. Gen. Hal B. Jennings, Jr., Army Surgeon General, writes in the pamphlet. "Breakthroughs in military medicine have had a significant impact on the course of civilian medical practice, even as progress in civilian medicine has affected the military."—*AMA News Feature.*

Infectious Diseases Course

A "Cleveland Symposium on Infectious Diseases" will be held June 13 and 14 at the Cleveland Clinic. The registration fee will be $60. The postgraduate course will be co-sponsored by the American Society for Clinical Pharmacology and Therapeutics. For additional information, contact The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44106.

Heart Muscle Regeneration?

A University of Chicago research team is studying the possibility that damaged heart muscle cells can restore itself instead of producing scar tissue. Their studies indicate that apparently after the first four weeks of birth the heart muscle cells are incapable of cell division and DNA synthesis.

Drs. Murray Rabinowitz and Donald Fischman along with Prof. Radovan Zak, conducted their experiments using pigs, monkeys, rats and mice.

The first project involved animals who were exposed to low oxygen atmosphere to demonstrate that mitochondria, essential to the production of energy for muscle functions, are destroyed. The goal is to obtain information about how these repair processes are controlled in order to minimize cell death and to obtain optimal return of function.

Another project presently under way involves the effects of lysosomes (an enzyme) and their effects on cardiac muscle cells. The possibility that these enzymes may lead to additional intracellular damage in infarcted pigs and monkeys is being examined.

The researchers are also studying the advantages of prolonged exercises. They had animals "conditioned" on a treadmill and evaluated, by stressing the hearts with other procedures, the effects of overworking the heart. The results of oxygen starvation was combined with the exercise as part of the investigation.

Fischman, Zak, in collaboration with Dr. Rabinowitz, are studying why cardiac muscle cell division, in adults, restricts itself. It is of great importance to determine if adult heart muscle cells can be made to reinitiate cell division and to regenerate. In this way, dead muscle can possibly be replaced by normal muscle rather than scar tissue. An intensive study of the development of cardiac muscle cells at varying ages — embryo, young, and adult — in tissue cultures, is under way.

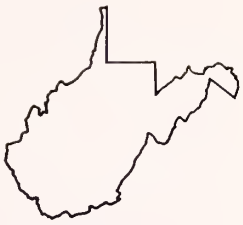
According to the National Society for Medical Research, continuing progress in the battle against heart attacks and related cardiac disease depends on new information obtained through animal experimentation.

A Place To Die

There was a time when public hospitals were a place one went to die. Happily that era has passed, and now one goes to the hospital in order to be made well. The strict new criteria for length of stay in a hospital, and the definitions of active treatment are forcing us to look very closely at the types of patient we admit to the hospital.

Soon we shall have pre-admission boards, and committees to examine the reason for admission. Their usefulness cannot be denied, in order to prevent abuse. But oh dear, I think that it won't be long before the only fully justifiable reason to admit a patient to the hospital will be as a place to die. —*Westchester Medical Bulletin.*

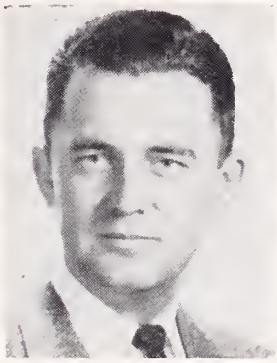
GENERAL NEWS



Drs. Muller and Watne To Speak At 106th Annual Meeting

Dr. A. Thomas McCoy of Charleston, Chairman of the Program Committee, has announced that Dr. William H. Muller, Jr., and Dr. Alvin L. Watne have accepted invitations to present papers during the 106th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 22-25.

William H. Muller, Jr., M. D.



Alvin L. Watne, M. D.

Doctor Muller will participate in a "Symposium on New Concepts in the Medical and Surgical Coronary Artery Disease" at the first general scientific session on Thursday morning, August 23. His subject will be "Surgical Aspects of Coronary Artery Disease."

Doctor Watne will present a paper on "Colon Polyposis and Colon Cancer" at the second general scientific session on Friday morning, August 24.

William H. Muller, Jr., M. D.

Dr. William H. Muller, Jr., Professor and Chairman of the Department of Surgery at the University of Virginia School of Medicine in Charlottesville, is a native of Dillon, South Carolina. He was graduated from the Citadel and received his M.D. degree in 1943 from the Duke University School of Medicine. He interned and served residencies at the Johns Hopkins Hospital in Baltimore and served as a Captain in the Medical Corps of the United States Army from 1946 to 1947. He was engaged in the private practice of general surgery for one year at Dillon, South Carolina.

Doctor Muller was a member of the faculty at the Johns Hopkins Hospital for one year before joining the faculty at the University of California at Los Angeles School of Medicine. He remained there from 1949 until 1954 when he accepted his present position at the University of Virginia.

He is a Diplomate of both the American Boards of Surgery and Thoracic Surgery and is a Regent of the American College of Surgeons. He served for a year as Vice Chairman of the American Board of Surgery and is a Past President of the Society of University Surgeons. He has served since 1959 as a member of the Advisory Council to The Greenbrier Clinic and served for five years as Editor of the *Transactions of the American Surgical Association.* He also served as a member of the Editorial Board of the *Virginia Medical Monthly* from 1958 to 1965 and he is a member of the Editorial Boards of several other national surgical journals.

Alvin L. Watne, M. D.

Dr. Alvin L. Watne, Professor of Surgery at the West Virginia University School of Medicine, is a native of Shabbona, Illinois.

He was graduated from the University of Illinois and received his M.D. degree in 1952 from the University of Illinois College of Medicine. He also received an M.S. degree in surgery in 1956 from the University of Illinois Graduate School of Medicine. He interned at Indianapolis General Hospital and served a residency at the University of Illinois Research and Education Hospital.

Prior to joining the faculty at the WVU School of Medicine, Doctor Watne was Associate Chief Cancer Research Surgeon at Roswell Park Memorial Institute in Buffalo, New York. In addition to his duties as Professor of Surgery, Doctor Watne occupies the Charleston Foundation Chair of Cancer Research at the WVU School of Medicine.

A Diplomate of the American Board of Surgery, Doctor Watne served during the past year as President of the West Virginia Chapter of the American College of Surgeons. He also is currently serving as Chairman of the Cancer Committee of the State Medical Association.

Varied Scientific Program Planned

Doctor McCoy announced previously that two other prominent physicians will join with Doctor Muller in participating in the Symposium which has been planned for the first general scientific session on Thursday morning, August 23. They are Dr. C. Richard Conti, Associate Professor of Medicine at the Johns Hopkins University School of Medicine; and Dr. James J. Morris, Jr., Associate Professor of Medicine at the Duke University School of Medicine.

Doctor Conti will present a paper on "Medical Therapy of Angina Pectoris" and Doctor Morris will speak on "Angiographic and Hemodynamic Aspects of Coronary Artery Disease."

In addition to Doctor Watne, it was announced previously that Dr. Theodore M. King, Professor and Director of the Department of Gynecology and Obstetrics at the Johns Hopkins University School of Medicine, and Dr. John A. Kirkpatrick, Jr., Professor of Radiology and Pediatrics at the Temple University School of Medicine, will present papers at the second general scientific session on Friday morning, August 24.

Doctor Roth to Deliver Address

Dr. Russell B. Roth of Erie, Pennsylvania, President Elect of the American Medical Association, will deliver an address before the first session of the House of Delegates on Wednesday afternoon, August 22. Doctor Roth will be installed as President of the AMA at the Annual Convention in New York City in June.

Other business sessions include a meeting of the Council on Wednesday morning and the final session of the House of Delegates on Saturday afternoon, August 25.

Additional information concerning the 106th Annual Meeting at The Greenbrier in August will be announced in future issues of *The Journal.*

Physicians Reminded To Report VD Cases to Health Dept.

Dr. William L. Cooke, Director of the Division of Disease Control of the West Virginia State Department of Health, announced that in 1972 there were 868 cases of syphilis reported to the Bureau of Venereal Disease Control in West Virginia.

He said that 605 cases were reported from private practice and the remainder from clinics.

For the same period of time, he said 1,953 cases of gonorrhea were reported; but only 427 from private physicians while 1,526 were clinic patients.

Doctor Cooke has reminded physicians practicing in West Virginia that, by law, both of these diseases are reportable.

Conference On Cancer In Fall

A national conference on "Virology and Immunology in Human Cancer" will be held November 29 and December 1 in New York City at the Waldorf-Astoria Hotel. It is sponsored by the American Cancer Society and the National Cancer Institute.

Pre-registration is requested. There is no registration fee.

For additional information contact Sidney L. Arje, M. D., National Conference on Virology and Immunology in Human Cancer, American Cancer Society, Inc., 219 East 42nd Street, New York, New York 10017.

New Procedural Terminology Edition Published By AMA

More than 2,000 new and revised medical procedures are listed in the Third Edition of the American Medical Association's *Current Procedural Terminology,* off the press this spring.

CPT is a listing of medical terms and identifying codes for reporting medical services and procedures performed by physicians. The book provides a uniform language to designate accurately medical, surgical and diagnostic services, thereby providing an effective means for reliable, nationwide communication among the providers of medical care, the patient and third party payers and carriers.

In recent years, the reporting requirements by third parties and the emphasis on the delivery, utilization and evaluation of medical care have been matters of concern to physicians. These factors have caused a greatly increased volume of paper work for physicians and have stressed the need for accurate reporting of services rendered.

CPT was created by the AMA to provide for physicians a means to identify services in a uniform manner and to facilitate record keeping both by the physician and by the third party payer, such as Medicaid, Blue Shield or private insurance.

The common language may also be related to medical research and education and may provide a useful basis for which variations for local and regional utilization as well as national application and comparability can be developed.

The Third Edition of *CPT* has been prepared and studied by physicians, aided by consultants, from the various medical specialties. The text can be used in the development of billing systems, for administrative management purposes and in the development of guidelines for medical care review.

In applying the common language of *CPT* for use in computers, a five-digit code is utilized. The use of *CPT* code simplifies the reporting of services. The physician using *CPT* terminology with coding selects that procedure which most accurately describes the service performed. This is the basic service. In surgery, it may be an operation; in medicine, an office visit; in x-ray, a chest radiograph. Other procedures performed in addition to the basic service also may be listed.

The main body of the material is listed in five sections: Medicine, Surgery, Radiology, (including Nuclear Medicine and Diagnostic Ultrasound) Pathology, and Laboratory, and Anesthesiology.

A complete alphabetical index is in the back of the book. Specific guidelines for using the book and its codes are presented at the beginning of each of the five sections.

The Third Edition of *CPT* was prepared under the direction of the AMA's Committee on Computer Systems in Medicine. Chairman is Richard E. Palmer, M. D. Doctor Palmer also is chairman of the *CPT* editorial board. Consultants from 27 different medical and surgical specialty societies assisted in the work.

Potential Role Of Acupuncture To Be AMA Convention Topic

The potential role of acupuncture in the practice of medicine in the western world will be assessed for members of the American Medical Association at the annual convention June 23-27 in New York City.

Four major speakers who are experts in various aspects of acupuncture and Chinese medicine will present papers analyzing this ancient oriental technique at the three-hour session, scheduled for Wednesday afternoon, June 27, in the grand ballroom of New York's Hilton Hotel.

William Lukash, M. D., a White House staff physician who accompanied President Richard Nixon on his trip to China, will make the introductory remarks.

The other speakers and their topics will be:

Ilza Veith, Ph. D., Professor and Vice Chairman of the Department of the History of Health Sciences at the University of California San Francisco Medical Center — "Acupuncture — History, Philosophy and Cultural Background."

Walter H. Judd, M. D., former U. S. congressman, and former medical missionary to China—"A Westerner Views Chinese Medicine."

James Y. P. Chen, M. D., Director of Medical Research for the California Medical Group, Los Angeles, and member of the Ad Hoc Committee on Acupuncture of the National Institutes of Health —"Current Status of Acupuncture and Acupuncture Anesthesia."

David M. Link, of the U. S. Food and Drug Administration, Rockville, Maryland — "Acupuncture Devices—Problems in Regulation."

The speakers will be queried by a panel composed of Howard Rome, M. D., Head of Psychiatry for the Mayo Clinic, Rochester, Minnesota, former chairman of the AMA's Council on Mental Health; John Dillon, M. D., Head of Anesthesiology at the Medical School of the University of California at Los Angeles, member of the AMA's Council on Scientific Assembly; and Jules Bergman, Science Editor of the American Broadcasting Company. This will be followed by a question and answer period.

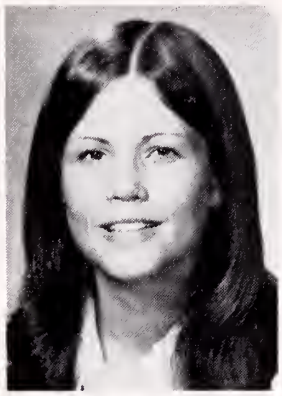
Anesthesia Conference

"Drugs and Techniques in Anesthesia" will be the topic of a conference at the University of Kentucky College of Medicine June 1-2. The program will provide a review on the drugs and techniques in anesthesia for general practitioners and anesthesiologists.

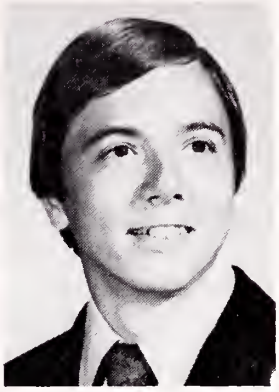
Eleven hours of AAFP credit have been requested. The registration fee is $50. For further information contact Ronald D. Hamilton, M. D., Director of Continuing Eduaction, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Two Young Students Awarded Medical Scholarships

Two young West Virginia students have been awarded four-year scholarships to the West Virginia University School of Medicine by the West Virginia State Medical Association.



Miss Rhonda Kay Brennan



D. Gregory Bott

Dr. Martha J. Coyner of Harrisville, Chairman of the Association's Committee on Medical Scholarships, said that the recipients of this year's awards will be Rhonda Kay Brennan of Sarah Ann (Logan County) and D. Gregory Bott of Rio (Hampshire County). They will receive $1,000 apiece for each of their four years at the School of Medicine for a total of $4,000 each.

Both students have been accepted by the School of Medicine to begin studies next fall leading toward M. D. degrees.

Miss Brennan was educated in the public schools of Logan County and is the daughter of Mr. and Mrs. William A. Brennan. She will receive a B. S. degree in biology in May from Concord College.

Bott is scheduled to receive an A. B. degree in biology in May from West Virginia University. He is the son of Mr. and Mrs. Floyd W. Bott and was graduated from Hampshire High School in Romney.

Miss Brennan and Bott are the 27th and 28th deserving students to receive grants since the State Medical Association started the program in 1958.

The full Medical Scholarships Committee met in Morgantown on Saturday and Sunday, March 31 and April 1, to interview the 24 applicants for the Association grants.

Committee members present for the interviews were the Chairman, Doctor Coyner, and Drs. John Mark Moore of Wheeling, Clark K. Sleeth of Morgantown, Thomas J. Holbrook of Huntington, Robert D. Hess of Bridgeport and Marshall J. Carper and Russel Kessel, both of Charleston. Also present were Mr. William H. Lively, Executive Secretary of the State Medical Association, and Mr. Custer Holliday, Executive Assistant.

Dr. Brown New President Of State AAFP Chapter

Dr. Donald P. Brown of Kingwood was installed as President of the West Virginia Chapter of the American Academy of Family Physicians at the group's 21st annual meeting in Morgantown April 6-8 at the Lakeview Inn and Country Club.

Named President Elect was Dr. William D. Crigger of South Charleston.

Doctor Brown has served twice as President of the Preston County Medical Society. He earned an A. B. degree and B. S. degree in medicine at West Virginia University, receiving his M. D. degree in 1944 from the George Washington University School of Medicine.

Doctor Crigger has been located at South Charleston since starting family practice there in 1951. A Fellow of the AAFP, he also is a Diplomate of the American Board of Family Practice. He is a Past President (Chief of Staff) of Thomas Memorial Hospital at South Charleston, and also is a Past President of the Kanawha Chapter of the AAFP.

A graduate of Marshall University, he received his M. D. degree in 1953 from Temple University.

Other officers elected were Drs. John W. Traubert, Wellsburg, Vice-President; Ray M. Kessel, Logan, Secretary; and Margaret I. Stemple, Morgantown, Treasurer.

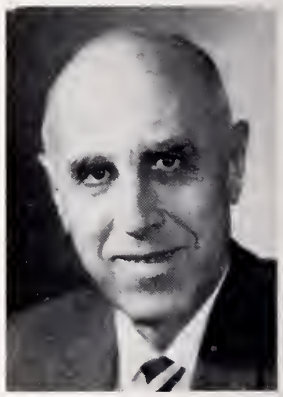
Dr. James L. Grobe, a Huntington native, who is President of the national AAFP, was guest speaker at the annual banquet on April 7. Doctor Grobe said an increase in the training for practice of "family medicine" is required by the changing character of illnesses which requires that health care must increasingly be taken to people in an office setting rather than hospitals. Noting that the WVU Medical Center is organizing a Department of Family Practice, he said that 66 of the nation's nearly 90 operating schools of medicine already offer specialized family practice training.

Dr. James L. Grobe (seated, left) talks with officials of the West Virginia University Medical Center in conjunction with his visit to Morgantown as principal speaker at the annual meeting of the West Virginia Chapter of the American Academy of Family Physicians which was held April 6-8. Doctor Grobe, who also spoke to students at the Medical Center, is shown with Drs. Charles E. Andrews (seated, right), Provost of Health Sciences; and standing, from left, David Z. Morgan, Associate Dean, School of Medicine; and Clark K. Sleeth, Acting Chairman, Department of Family Practice.

Dr. Clark K. Sleeth, Acting Chairman of the new Department of Family Practice, also spoke at the banquet. Doctor Sleeth said the new department will focus on the importance of health maintenance before treatment of illness. In reviewing current developments in the Family Practice program, he stated, "West Virginia University School of Medicine continues to be committed to the conduct of a program in Family Practice, and will proceed with implementation as rapidly as possible, consonant with meeting the requirements of the various professional and public agenices concerned, and contingent upon the availability of the fiscal resources for such a program."

AMA Vice-President Speaks At Charleston Reception

Dr. Norman H. Gardner, Vice-President of the American Medical Association, was keynote speaker at a special reception honoring Mrs. Morton A. Lewis on April 18 in Charleston. Mrs. Lewis, of Charleston, was selected as the 1973 "Distinguished Woman of the Year" by the Allergy Rehabilitation Foundation, Inc., Charleston, for her work on behalf of Bronco Junction, the summer camp for asthmatic children at Red House in Putnam County.



Norman H. Gardner, M. D.

Community leaders and representatives from numerous civic organizations in the Charleston and Huntington areas attended the afternoon reception, which was held at the Holiday Inn Charleston House.

The reception honored not only Mrs. Lewis, but all the women who have worked behind the scenes to make the Bronco Junction program successful, according to Dr. Merle S. Scherr of Charleston, Medical Director of the Foundation, and Willard H. Erwin, Jr., Foundation President.

Doctor Gardner has been in family practice in East Hampton, Connecticut since 1935. A graduate of Tufts University Medical School at Medford, Massachussetts, he currently is on the staff of Middlesex Memorial Hospital in Middletown, Connecticut. He was the East Hampton Medical Examiner and Health Director for 33 years and the Health Director for Marlborough, Connecticut for 15 years.

Physicians Invited To Hear English Surgeon In Morgantown June 15

Denis P. Burkitt, M.S.F.R.S., internationally recognized English surgeon, will speak at a dinner meeting of the Monongalia County Medical Society on June 15, it was announced by Dr. Alvin L. Watne, Professor of Surgery at the West Virginia University Medical Center.

Doctor Burkitt also will lecture at the WVU Medical Center on the same date at 4 P. M. The dinner meeting of the Medical Society will be held at 6:30 P. M. at the Lakeview Inn and Country Club in Morgantown.

Doctor Watne said physicians are cordially invited to hear Doctor Burkitt. Those wishing to attend the dinner meeting are requested to contact Doctor Watne's office at the medical center for reservations. The telephone number is 293-3041.

During the 1950's and 60's Doctor Burkitt located lymphoma in African children, which now bears his name. He received the Lasker Award in 1972 for this work and continuing work in epidemiology of cancer throughout the world.

Doctor Watne said Doctor Burkitt will be a visitor at the medical center on June 14 also.

State Physicians Invited To Investiture Ceremony

The Investiture ceremony honoring the 1973 graduating seniors of the West Virginia University School of Medicine will be held on the evening of May 19 in the main auditorium of the Creative Arts Center on the Evansdale Campus, it was announced by Dr. Roland Schmidt, Chairman of the Commencement Committee.

The proceedings will begin at 7:30 with an organ recital by Dr. Clyde English. The academic procession will get under way at 8 o'clock.

Doctor Schmidt said that all state physicians are cordially invited to attend.

Cleveland Clinic Courses

The Cleveland Clinic Educational Foundation has announced two postgraduate courses during May: "Advances in Dermatology," May 9 and 10; and "Gastrointestinal Endoscopy," May 12.

Registration fees will be $60 for the dermatology course and $30 for the other course.

Registration and fees should be sent to The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44106.

New officers of the West Virginia Chapter, American Academy of Family Physicians, are shown following their election at the group's 21st Scientific Assembly in Morgantown, April 6-8. Seated, from left, are Drs. William D. Crigger, South Charleston, President-Elect; Margaret Stemple, Morgantown, Treasurer; Donald P. Brown, Kingwood, President. Standing are Drs. John W. Traubert, left, Wellsburg, Vice-President; and Ray M. Kessel, Logan, Secretary.

Dr. Ladewig Named Fellow In Forensic Sciences

Dr. Peter P. Ladewig, Chairman of the Charleston Area Medical Center's Pathology Division, has been named a Fellow in the American Academy of Forensic Sciences.

He becomes the only West Virginian to hold the distinction and only one of approximately 35 in the United States.

Dr. Peter P. Ladewig

Doctor Ladewig, who has gained renown in courts and police circles throughout the state for his postmortems in criminal and civil cases, was notified of the honor in a letter from Dr. James T. Weston, the Academy's Secretary-Treasurer and Professor of Pathology at the University of Utah.

"This is a deserved recognition for substantial contributions you have made to the administration of justice through the efforts of the Academy," Doctor Weston wrote.

Doctor Weston said the selection was made at the last annual meeting of the Academy in Dallas, Texas.

Doctor Ladewig, who was born in Berlin, Germany, received his M. D. degree in 1933 from the University of Berlin. He did postgraduate work in pathology there and at the University of Istanbul (Turkey). He began practice in West Virginia in 1953.

Looking Back 10 Years . . .

Dr. Seigle W. Parks of Fairmont, left, then newly elected Vice President of the West Virginia State Medical Association, was shown with Dr. L. J. Pace of Princeton, the immediate Past President, during the 96th Annual Meeting at The Greenbrier.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

May 3-5—ACS, W. Va. Chapter, White Sulphur Springs.
May 2-5—Am. Gyn. Soc., Colorado Springs, Colo.
May 4-5—W. Va. Ob. & Gyn. Clinical Workshop, Charleston.
May 5—W. Va. Soc. of Anesth., Morgantown.
May 7-9—Am. Col. of Sports Med., Seattle.
May 7-11—Am. Psych. Assn., Honolulu.
May 7-11—Ohio State Med. Assn., Columbus.
May 13-17—Am. Urol. Assn., New York City.
May 17-19—Am. Ped. Soc., San Francisco.
May 20-23—Nat. TB & RD Assn., New York City.
May 20-26—Am. Gastro. Assn., New York City.
May 21-24—Am. Col. of Ob. & Gyn., Bal Harbour, Fla.
May 21-24—Am. Thoracic Soc., New York City.
May 22-24—Va. Heart Assn., Fredericksburg.
May 28-30—Am. Ophth. Society, Hot Springs, Va.
May 27-31—Med. Library Assn., Kansas City.

June 10-14—Am. Proctologic Soc., Detroit.
June 15-17—Pa. Allergy Assn., Hershey.
June 22-23—Am. Diabetes Assn., Chicago.
June 23-28—AMA, New York City.
June 24-27—Am. Assn. of Plastic Surgeons.

Aug. 19-20—Am. Acad. Med. Administrators, Chicago.
Aug. 20-23—Am. Health Congress, Chicago.

Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 6-8—Am. Assn. Ob. & Gyn., Hot Springs, Va.
Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-20—Ky. Medical, Louisville.
Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.
Sept. 18-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 20-23—Am. Soc. Internal Med., Dallas.
Sept. 27-29—Natl. Conf. Cancer of Colon & Rectum, Bal Harbour, Fla.

Oct. 1-4—AAFP, Denver.
Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 7-11—Am. Soc. Anesth., San Francisco.
Oct. 15-19—ACS Clinical, Chicago.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.
Oct. 21-26—Am. Acad. Physical Med. & Rehab., Washington.
Oct. 26-28—Pot.-Shen. PG Institute, Martinsburg.

Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-13—Am. Heart Assn., Atlantic City.

Nov. 12-15—Sou. Medical Assn., San Antonio.

Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.

1974

Jan. 19-20—Mid-Winter Clinical Conf., Charleston.

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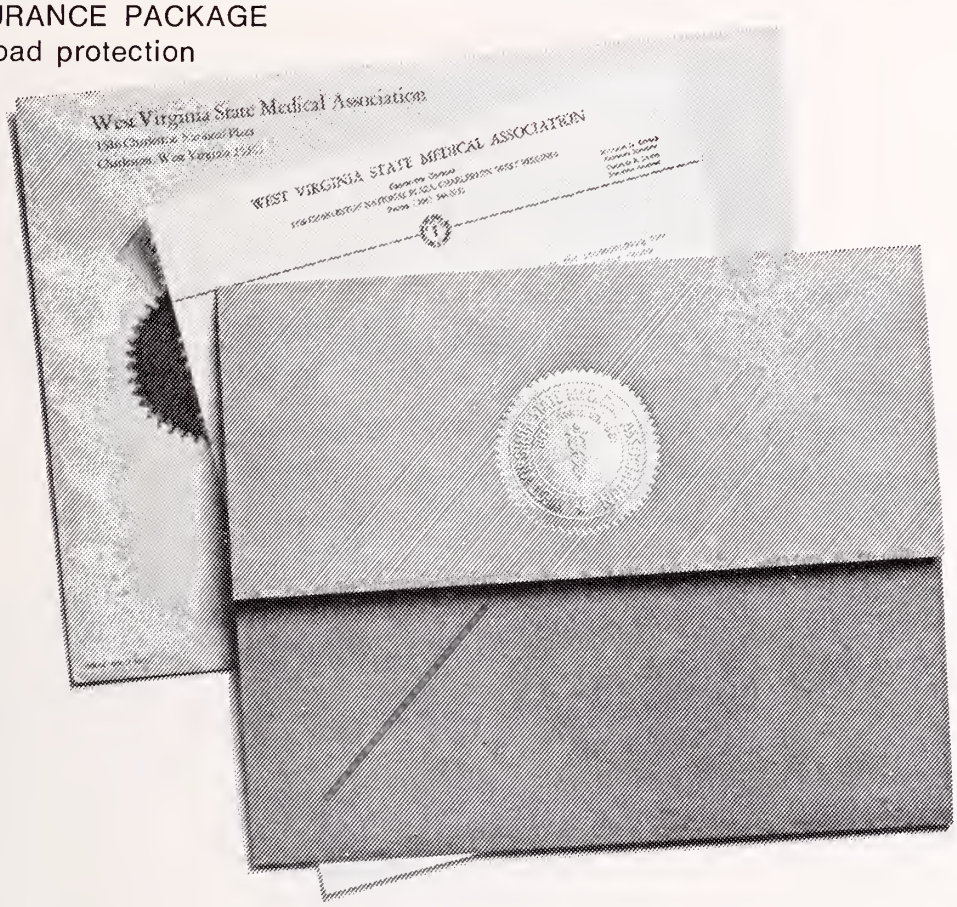

This informative brochure describing the unique WVSMA insurance program has been mailed to every member. If you are interested in the plan, mail the reply card promptly. If you would like further details contact WVSMA or your local Ætna Life & Casualty agent.

WVU Medical Center
–News–

DR. Gideon Stanhope Dodds was a prominent scientist whose career as a teacher of histology and embryology at West Virginia University School of Medicine spanned 33 years (1918 to 1951) and longer, counting his continued activities as a Professor Emeritus until shortly before his death at 90 in 1971.

Besides his teaching, the textbook he wrote, and the historical treatises he co-authored during his long career, he gathered, preserved and documented one of the world's most comprehensive, unusual and educational collections of embryos and fetuses.

Known as the Dodds Collection, the specimens form the nucleus of a fascinating museum in the WVU Medical Center's Department of Anatomy.

By pre-arrangement with the department, hundreds of school and science groups visit the museum while on tour at the Medical Center. It is perhaps their most interesting stop, and certainly Doctor Dodds' great legacy makes it so.

Museum Completely Reorganized

To present the museum's collection in an even more outstanding way, two members of the Department of Anatomy faculty recently completed reorganizing, framing and formally cataloging the specimens. Dr. Rusi Hilloowala and Dr. Frances Higginbotham carefully planned and remodeled the exhibit over a period of several months. Aided by Kathy Redfoot, a pre-nursing freshman from Derry, Pennsylvania, who joined in the project, the professors have heightened the collection's impact as a teaching resource.

- **Compiled from moteriol furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Informotion Services, Morgontown, W. Va.**

Inside the lighted exhibit cases in ordered sequence are examples of the normal pregnant uterus, development of the embryo in stages through the first 10 weeks and continuation to term of fetal development, the placenta, the umbilical cord, ectopic pregnancy, aborted fetuses, fetal dissection, and the twinning process with a detailing of incidence of multiple births. Abnormal examples follow, including conjoined twins and severe congenital defects such as sirenomelus (fused lower extremities) and anencephalic acrania (absence of cerebrum, cerebellum and flat bones of the skull).

Dr. Donald H. Enlow, Chairman of the Department of Anatomy, is proud of the museum's contents and its new look. "Its educational value is enormous, surpassing textbooks, diagrams and charts on the subject," said Doctor Enlow. "We hope the interest it generates will influence many of our young visitors to become medical students."

Surveying their results after reorganizing and remodeling the famed Dodds Collection of embryos and fetuses at West Virginia University Medical Center's Department of Anatomy are (from left) Kathy Redfoot, a pre-nursing freshman from Derry, Pennsylvania; Dr. Rusi Hilloowala, Assistant Professor, and Dr. Frances Higginbotham, Associate Professor. The specimens are part of an exhibit that attracts hundreds of visitors each year.

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James A. Gardner, M. D.

Orthopedics
Clifford A. Stevenson, M. D.
S. A. Zahir, M. D.
Mario C. Ramas, M. D.

Obstetrics-Gynecology
Charles W. Merritt, M. D.
Warren D. Elliott, M. D.
Owen C. Meadows, M. D.
Robert P. Pulliam, M. D.
T. J. Ma-Luf, M. D.

Ophthalmology
Edward T. Liu, M. D.

Urology
S. L. Francis, M. D.

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R. James Yates, M. D.

Pediatrics
P. B. Gogo, M. D.
R. G. D. Concepcion, M. D.

Ear, Nose & Throat
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Radiology
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Asst. Administrator

The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE Administration has notified the American Medical Association it is "prepared to review thoroughly the regulations governing the medical profession" in the Phase 3 controls that continue the limits on physicians' fee increases.

The Administration's letter avoided a direct reply to the AMA's petition of January 15 to President Nixon urging that physicians be exempted from the Phase 3 controls as has been most of the rest of the economy.

John Dunlop, Director of the Cost of Living Council, said the President had asked him to respond to the AMA letter. Dunlop, said, "Having assumed responsibility for the economic stabilization program last month, I am now prepared to review thoroughly the regulations governing the medical profession."

"As you know," wrote Dunlop to John R. Kernodle, M. D., Chairman of the AMA Board of Trustees, "the health field has been persistently among the most inflationary areas in our economy, and I am sure it is our goal to alter that trend."

The AMA had told the President that physicians' fees rose only 1.7 per cent during the first 12 months of Phase 2. ". . . we have surpassed the original expectations," said Doctor Kernodle in the AMA letter to the President. "In view of our demonstrated success during the past year, you can imagine our dismay . . . that the medical profession has once again been singled out under special controls."

Dunlop's letter did not mention the AMA's request for a meeting with President Nixon and his top economic advisers to discuss the issue.

In his letter to Doctor Kernodle, Dunlop said: "We are presently in the process of appointing members to the new Health Industry Advisory Committee and I assure you that the views of physicians will be represented on that committee. As soon as an executive director for the committee is named, I will have him contact you for suggestions on how best to meet our goals for controlling health care costs under Phase 3.

"Meanwhile, I know the federal government can count on your cooperation in following the legal requirements now in effect, and I look forward to working with you to evaluate new alternatives."

Human Research Subjects Essential

The use of human subjects in medical research is essential for the benefit of society despite the fact that it will place some participants at a calculated disadvantage, the American Medical Association told Congress.

The AMA comments were made to Senator Kennedy's Senate health subcommittee in hearings on the subject of human experimentation and whether a need exists for federal legislation to forestall abuses.

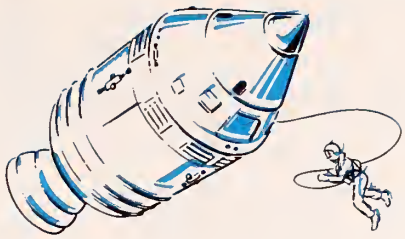
William R. Barclay, M. D., Assistant Vice-President of the AMA, told the senators that, "The practice of medicine is both an art and a science, and we are constantly seeking new means to improve the quality and length of life. The evolution of sound medical practice through the years has reduced the incidence of pain and has done much to advance the cause of human dignity. These procedures, however, today as always, require the weighing of risk against benefit at every level of professional discretion. It is evident that there is a certain degree of risk attendant to any medical procedure.

"But if we are to continue to improve our high standards of patient care, we must maintain our initiatives in biomedical research. The accomplishments of modern medical practice testify to the merits of continued research. Such advances are hard won, the benefits are beyond question.

"Medicine as a science must conduct experimentation if it is to progress rather than stagnate. Experimentation is an essential principle of all sciences, be they biological or physical. Scientific experiments are conducted both to test new hypotheses and to reexamine the validity of accepted hypotheses.

"A medical experiment with human subjects is sometimes referred to as a clinical trial. As such it should be a test of a reasonable hypothesis based on sound laboratory data. It should not be a random groping for information. A well designed clinical trial has elements in its design which assure that it will be useful and a justifiable undertaking.

". . . A human experiment, by its very nature, establishes a set of circumstances which will place some of the participants at a calculated disadvantage. Generally a trial is established to answer the question, 'Is treatment A better than treatment B?' No definitive answer to this question can be obtained until the test is conducted over an adequate period of time and sufficient data has been gathered by which to measure the relative response of the subject.



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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinaations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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During pregnancy or when K.I. is contraindicated or not tolerated

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Diplomate, American Board of Ophthalmology

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Maxillo-facial Surgery
Reconstructive Surgery
Head & Neck Surgery
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Endoscopy
Oncology

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John B. Haley, M.D.
John A. B. Holt, M.D.
Diplomate, American Board of Ophthalmology

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Orthoptics
Visual Fields—Flow Studies
Laboratory
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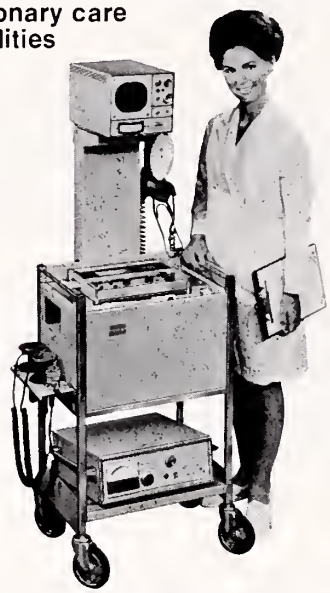

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HUNTINGTON, WEST VIRGINIA

Obituaries

WILLARD F. DANIELS, M. D.

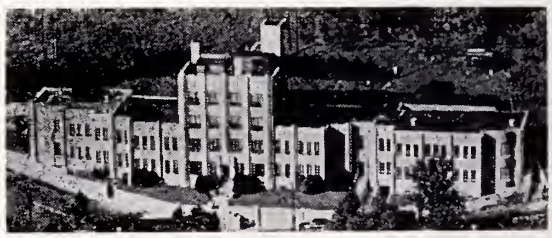
Dr. Willard F. Daniels, of Huntington, died on March 6 in a hospital there. He was 66.

A resident of Huntington for 40 years, Doctor Daniels, a general practitioner, was a native of Elkins.

Doctor Daniels was a graduate of West Virginia University, and received his M. D. Degree in 1929 from the University of Maryland College of Medicine. He interned at Jefferson Hospital in Roanoke, Virginia, and did postgraduate work at Cleveland Clinic. He served in the U. S. Navy during World War II.

Doctor Daniels was a member of the Cabell County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Survivors include the widow; one daughter, Mrs. Thomas Russell of Orlando, Florida; and two sons, Dr. Willard F. Daniels, Jr., and Dr. David Daniels, both of Huntington.



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Pathology:
Fulvia Franyutti, M. D

Surgery:
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
T. H. Chang, M. D.

Gynecology and Obstetrics:
Raymond W. Cranlund, M. D.

Internal Medicine:
E. G. Guy, M. D.
B. G. Thimmappa, M. D.
Karl J. Myers, Jr., M. D.

Pediatrics:
D. F. Manger, M. D.
E. G. Kreider, M. D.

Anesthesiology:
G. E. Hartle, M. D.

Dentistry:
Glenn B. Paling, D. D. S.

Broaddus Hospital Resident Staff:
Yaung Chung Fan, M. D.
Vincente Narciso, M. D.
Ramprasad Patnaik, M. D.
Sangsiddhi Chinnapangse, M. D.

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County Societies

CABELL

An ad hoc committee of the Cabell County Medical Society will be established, it was announced by President Thomas F. Scott, M. D., at the meeting of the Society on March 8 in Huntington.

Doctor Scott said the committee would study school boy athletic injuries in the Huntington area and study recruitment of primary physicians for the area.

Col. Maurice M. Reeder, Chief of the Radiology Department at Walter Reed Army Hospital, gave an interesting talk about "Differential Diagnosis" in interpretation of x-rays.

A moment of standing silent prayer was taken in memory of the late Dr. W. F. Daniels, Sr.

* * * *

MERCER

Dr. A. R. Piracha of Princeton spoke at the meeting of the Mercer County Medical Society on March 19 at the University Club in Bluefield. Doctor Piracha reported on a recent American Cardiology meeting and discussed the X-Syndrome of angina pectoris in young women. He also reviewed a study of coronary artery disease treated surgically with a control group treated medically. He stated that 80 to 85 per cent of those who undergo surgery have symptomatic improvement but that it is questionable whether life is prolonged by coronary surgery.

It was announced that Medical Society dues were due by April 1.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Wilford W. Spradlin spoke at the meeting of the Monongalia County Medical Society on March 6 in Morgantown. Doctor Spradlin discussed the utilization of the Department of Behavioral Medicine at the West Virginia University Medical Center. He gave a short history of the development of the behavioral sciences and then explained the approach to the patient with behavioral problems at the medical center.

Dr. Isaiah A. Wiles, Chairman of the Public Health and Legislation Committee, gave his report.

Members were reminded of upcoming meetings in the Morgantown area, including the Spring Meeting of the State Chapter of the American Academy of Pediatrics, a one-day program on internal medicine at the WVU Medical Center, and the State Chapter of the American Academy of Family Physicians.

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Ear, Nose & Throat:
W. A. Tiu, M. D.

Orthopedic Surgery:
E. L. Barrett, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
A. Athari, M. D.

Urology:
D. C. Trapp, M. D.

Dermatology:
H. L. Saferstein, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
R. B. Armstrong, M. D.
C. A. Vasquez, M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.
Robert L. Mendelson, Ed D.

Roentgenology:
A. K. Butler, M. D.
J. N. Aceto, M. D.

Speech Pathologist and Audiologist:
James P. Frum, M. S.

Clinical Laboratories:
Donna Burlenski
Donna Bryan

Technologists:
Electracardiography:
Betty Maguire, R. N.
Brenda Muklewicz, R. N.
Electroencephalography:
Joann Green, R. N.
Juanita Stone, R. N.
Roentgenology:
Evelyn Farester, R. T.

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Annual Audit, 1972

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the Calendar year 1972 has been completed by the firm of Fitzhugh, Erwin, McKee & Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
716 Charleston National Plaza
Charleston, West Virginia 25301

West Virginia Medical Association
Charleston, West Virginia

We have examined the Statement of Assets, Liabilities, and Fund Balance Arising from Cash Receipts and Disbursements of the West Virginia State Medical Association as of December 31, 1972 and the related Statement of Changes in Fund Balances Arising from Cash Receipts and Disbursements, Statement of Cash Receipts and Disbursements on Account of Income and Expenses for the General Fund, Medical Journal Fund, Convention Fund, American Medical Association Fund and Medical Scholarship Fund for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements, presents fairly the assets and liabilities of the West Virginia State Medical Association, at December 31, 1972, arising from recorded cash transactions, and the revenues collected and expenditures made by it, and changes in fund balance during the year then ended, applied on a basis consistent with that of the preceding year after giving retroactive effect to the change, with which we concur, in the method of accounting for investments as described in Note 2 to the financial statements.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
February 21, 1973

STATEMENT OF ASSETS, LIABILITIES AND FUND BALANCES ARISING FROM CASH RECEIPTS AND DISBURSEMENTS AT DECEMBER 31, 1972

(Note 1)

ASSETS

			Un
CURRENT ASSETS			
Cash			$ 852.63
INVESTMENTS—(Note 2)			
Certificate of deposit 5% 4/9/69-74		$ 5,000.00	
Certificate of deposit 5% 4/9/69-74		5,000.00	
Certificate of deposit 5% 4/9/69-74		5,000.00	
Certificate of deposit 5% 4/9/69-74		5,000.00	
Certificate of deposit 5% 4/9/69-74		10,000.00	
Certificate of deposit 5% 4/9/69-74		10,000.00	
Certificate of deposit 5% 4/9/69-74		10,000.00	
Certificate of deposit 5¾% 12/21/72-74		12,500.00	
Series "J"	1/1/68	18.00	
Series "J"	1/1/68	18.00	62,536.00
			$63,388.63

			Re
MEDICAL SCHOLARSHIP FUND:			
Current Assets			
Cash		$28,714.56	
Due from General Fund		7,523.49	36,238.05
INVESTMENTS—(Note 2)			
Certificate of Deposit 5¾% 12/21/72-74			7,000.00
			$43,238.05

The accompanying notes are an integral part of this statement.

LIABILITIES AND FUND BALANCES

RESTRICTED		
CURRENT LIABILITIES		
Notes payable	$13,000.00	
Due to Medical Scholarship Fund	7,523.49	$20,523.49
FUND BALANCE		$42,865.14
		$63,388.63
STRICTED		
FUND BALANCE		$43,238.05
		$43.238.05

STATEMENT OF CHANGES IN FUND BALANCES ARISING FROM CASH RECEIPTS AND DISBURSEMENTS YEAR ENDED DECEMBER 31, 1972

(Note 1)

	General Fund
JANUARY 1, 1972 BALANCE	
As previously reported	$ 75,927.16
Investments (at cost) not previously recorded (Note 2)	62,373.33
JANUARY 1, 1972 AS RESTATED	138,300.49
RECEIPTS IN EXCESS OF DISBURSEMENTS	10,011.59
DISBURSEMENTS IN EXCESS OF RECEIPTS	—
	148,312.08
TRANSFER FROM GENERAL FUND TO OTHER FUNDS	(105,446.94)
	$ 42.865.14

The accompanying notes are an integral part of this statement.

UNRESTRICTED				RESTRICTED
Medical Journal Fund	Convention Fund	AMA Fund	Total	Medical Scholarship Fund
($59,924.50)	($20,623.64)	$-0-	($ 4,620.98)	$34,498.66
			62,337.33	6,284.59
(59,924.50)	(20,623.64)	-0-	57,716.35	40,783.25
			10,011.59	2,454.80
(18,903.00)	(5,995.80)	-0-	(24,898.80)	—
(78,827.50)	(26,619.44)		42,829.14	43,238.05
78,827.50	26,619.44			
$ -0-	$ -0-	$-0-	$42,829.14	$43.238.05

GENERAL FUND

Statement of Cash Receipts and Disbursements on Account of Income and Expenses for the Year Ended December 31, 1972

(Note 1)

RECEIPTS		
Dues allocated to General Fund	$115,042.50	
Commission on AMA dues collected	1,309.45	
Interest on bonds	312.50	
Contributions	800.00	
Registration to post graduate courses	1,070.00	
Gain on sale of bonds	162.67	$118,697.12
DISBURSEMENTS		
Salaries and wages	43,748.52	
Office supplies and expense	5,392.54	
Office rent	6,942.00	
Library	306.10	
Telephone and telegraph	4,008.54	
Postage	2,249.31	
Travel	21,850.76	
Mimeographing	331.80	

Expense of committee and council meetings	2,870.72	
Legislative bulletin expense	109.65	
Public health and public relations	503.51	
Payroll taxes	1,775.52	
Employee benefit plans— hospitalization	948.86	
retirement	4,764.59	
Dues and subscriptions	521.00	
Legal and accounting	1,174.38	
Miscellaneous	1,034.26	
Repayment of loans	10,153.47	108,685.53
RECEIPTS IN EXCESS OF DISBURSEMENTS		$ 10,011.59

The accompanying notes are an integral part of this statement.

MEDICAL JOURNAL FUND

Statement of Cash Receipts and Disbursements on Account of Income and Expense for the Year Ended December 31, 1972

(Note 1)

RECEIPTS		
Dues allocated to Journal Fund	$ 4,602.50	
Advertising	21,757.48	
Subscriptions	795.50	$27,155.48
DISBURSEMENTS		
Salaries	10,855.98	
Office supplies	984.47	
Postage	1,347.38	
Mimeographing	425.89	
Expense of committee and council meetings	25.49	
Dues and subscriptions	100.00	
Legal and accounting	175.00	
Printing	31,197.54	
Engraving	900.24	
Miscellaneous	40.00	
Travel	6.49	46,058.48
DISBURSEMENTS IN EXCESS OF RECEIPTS		($18,903.00)

The accompanying notes are an integral part of this statement.

CONVENTION FUND

Statement of Cash Receipts and Disbursements on Account of Income and Expense for the Year Ended December 31, 1972

(Note 1)

RECEIPTS		
Dues allocated to Convention Fund	$3,945.00	
Convention space	6,625.00	$10,570.00
DISBURSEMENTS		
Travel	1,281.95	
Printing	572.51	
Engraving	91.00	
Convention supplies and expense	5,742.84	
Expense of speakers	7,672.50	
Advances	130.00	
Auxiliary convention expense	1,075.00	16,565.80
DISBURSEMENTS IN EXCESS OF RECEIPTS		($ 5,995.80)

The accompanying notes are an integral part of this statement.

AMERICAN MEDICAL ASSOCIATION DUES FUND

Statement of Cash Receipts and Disbursements on Account of Income and Expense for the Year Ended December 31, 1972

(Note 1)

RECEIPTS		
Dues	$131,055.00	
Refund of dues	120.00	$131,175.00
DISBURSEMENTS		
Dues paid	131,055.00	
Refund of dues	120.00	131,175.00
RECEIPTS IN EXCESS OF DISBURSEMENTS		$ -0-

The accompanying notes are an integral part of this statement.

MEDICAL SCHOLARSHIP FUND

Statement of Cash Receipts and Disbursements on Account of Income and Expenses for the Year Ended December 31, 1972

(Note 1)

RECEIPTS		
Dues allocated to Medical Scholarship Fund	$7,890.00	
Interest on Treasury Bonds	175.00	
Contributions	500.00	
Repayment of scholarship awards	350.00	
Interest on savings	1,324.39	
Gain on sale of bonds	715.41	$10,954.80
DISBURSEMENTS		
Scholarship installments	8,500.00	8,500.00
RECEIPTS IN EXCESS OF DISBURSEMENTS		$ 2,454.80

The accompanying notes are an integral part of this statement.

NOTES TO FINANCIAL STATEMENTS

NOTE 1—ACCOUNTING POLICIES

The Association employs the cash basis of fund accounting and charges disbursements on account of expenses with office equipment and other capital expenditures at the time of purchase.

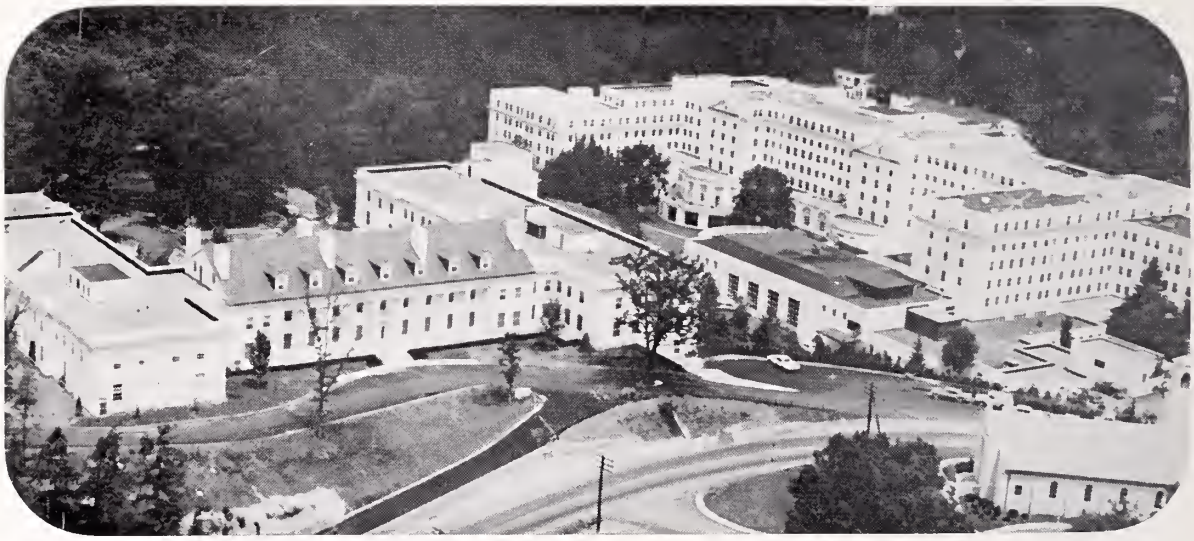
NOTE 2—PRIOR PERIOD ADJUSTMENT

Prior to 1972, the Association had included only cash in its fund balances with a separate presentation of investments. As of January 1, 1972 the fund balances have been adjusted to reflect the inclusion of these investments by funds for purposes of a clearer presentation.

106th ANNUAL MEETING

of the

West Virginia State Medical Association



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AUGUST 22-25, 1973

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SURGICAL RESIDENCY AVAILABLE: Large metropolitan hospital, fully accredited for residency training. Contact Bert Bradford, Jr., M. D., Director of Surgery, Charleston Area Medical Center, 3200 MacCorkle Avenue, S. E., Charleston, W. Va. 25304.

GENERAL SURGEON WANTED—Must have necessary qualities for advancement to Chief of Staff or Medical Director. Salary open. Medium size hospital in Southern West Virginia. Fully accredited with modern furniture and equipment. Contact CAW, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

NOTICE—Grafton City Hospital is pleased to announce its affiliation with Alderson-Broaddus College as a primary institution for the training of physicians assistants and nurses. Needed to augment the medical staff are a general practitioner, internist and an obstetrician-gynecologist. New hospital will be completed within three months and the training program will start in September 1973. Salary and subsidies can be arranged. Contact Wallace B. Murphy, M.D., Chief of Staff, Grafton City Hospital, Grafton, West Virginia 26354.

FAMILY PHYSICIANS—To practice at Jackson General Hospital and in the Ripley-Ravenswood area of West Virginia. Excellent opportunities in a prosperous area with tremendous growth potential. Salary guarantee for first year. Contact Administrator, Jackson General Hospital, Ripley, West Virginia 25271. Telephone: (304) 372-2731.

WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mayor J. Carl Rinehart, Pennsboro, W. Va.

WANTED—Excellent opportunity for qualified pediatrician; office space, equipment, staff and minimum first year's salary guaranteed by hospital. Send resume to Administrator, Pleasant Valley Hospital, Pt. Pleasant, W. Va. 25550.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

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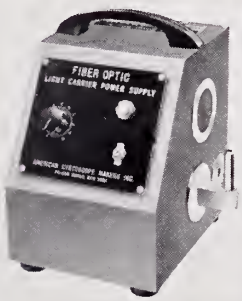

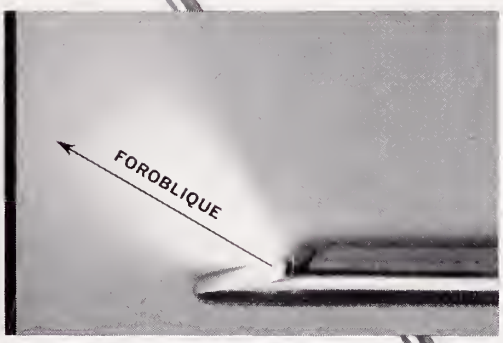

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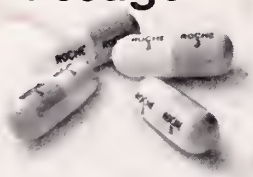

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Precautions: In the elderly and debilitat and in children over six, limit to smallest effec tive dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gra ally as needed and tolerated. Not recommende in children under six. Though generally not re ommended, if combination therapy with othe psychotropics seems indicated, carefully consid individual pharmacologic effects, particularly i use of potentiating drugs such as MAO inhibi and phenothiazines. Observe usual precaution presence of impaired renal or hepatic function Paradoxical reactions (*e.g.*, excitement, stimula and acute rage) have been reported in psychiat patients and hyperactive aggressive children. Employ usual precautions in treatment of anxi states with evidence of impending depression; suicidal tendencies may be present and protecti measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been establish clinically.

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the West Virginia Medical Journal

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Vol. 69 No. 6

W.D.S.

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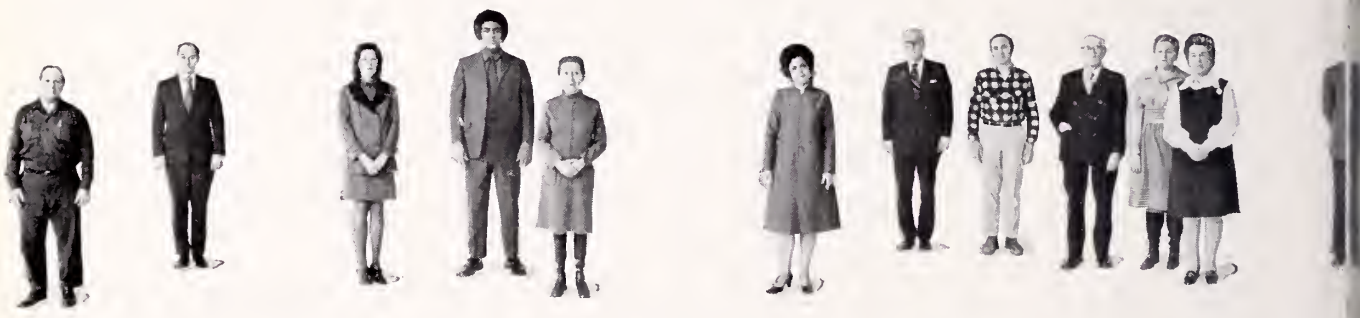

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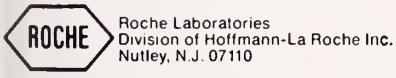

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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JUNE
1973

Vol. 69 No. 6

The
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Medical Journal

Official Organ of the West Virginia State Medical Association

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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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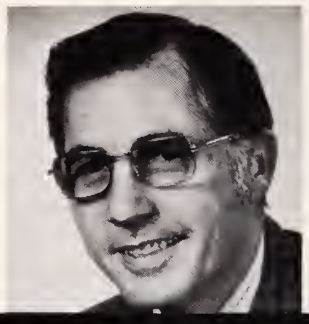
Opinion & Dialogue

"Prescription drugs – who should determine the maker?"



Dispenser of Medicine

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"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by form AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated ir crease in Blue Shield rates, Dr. Blas ingame's newsletter had this to say:

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to th patients . . .

"True, an MD's training is primarily scientific, but in the real wor of practice, all of his scientific decisions have a price tag, or an econon impact. The economics of health ca beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other tha the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nece sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmacis made in the absence of clinical knov edge of the patient, could expose hir to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothir in the pro-substitution argument tha offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledg about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will nee expert knowledge of no more than 25

Advertisement

ld be an obligation of medical ice...

"Medical societies ought to con- continuing campaigns to point ne substantial savings that could alized thru deductible insurance protection for catastrophic ill- At the very least, they should, in atients' interest, question the cs of any insurance organization raises health care costs by forc- olicyholders to buy insurance may not need or want and prob- won't ever use.

"Too many doctors are indiffer- o the economic consequences of decisions. Too many, for ex- le, habitually hospitalize patients ne convenience of the MD. It's ense to deny such habits exist...

"Doctors, thru their medical so- es, have unhesitatingly appealed eir patients for support in the against government interference the private practice of medicine. the public in the past has re- ded. It's time the American Med- Association and state and local ical societies paid off the debt by sive action to hold down the cost edical care."

of Drugs

Insurance rates and hospital ges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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0 drugs that he selects to treat the ority of conditions encountered in practice. Moreover, the physi- 's choice of a specific brand is ed on his knowledge of the pa- t's medical history and current dition, and his experiences with particular manufacturer's duct.

Some substitution proponents e argued that the dispensing of a scription is a simple two-party nsaction between the pharmacist the patient, and that a substitut- pharmacist may avoid even a nical breach of contract by simply fying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted hout physician approval and who lertook a legal defense that seeks nake the patient responsible for pharmacist's actions.

luced Prescription Prices?

Substitution advocates are gesting to the consumer, and par- larly the consumer activist, that luced prescription prices could ow legalization of substitution. have seen absolutely no evidence ustify this claim. To the contrary, perience in Alberta, Canada, where stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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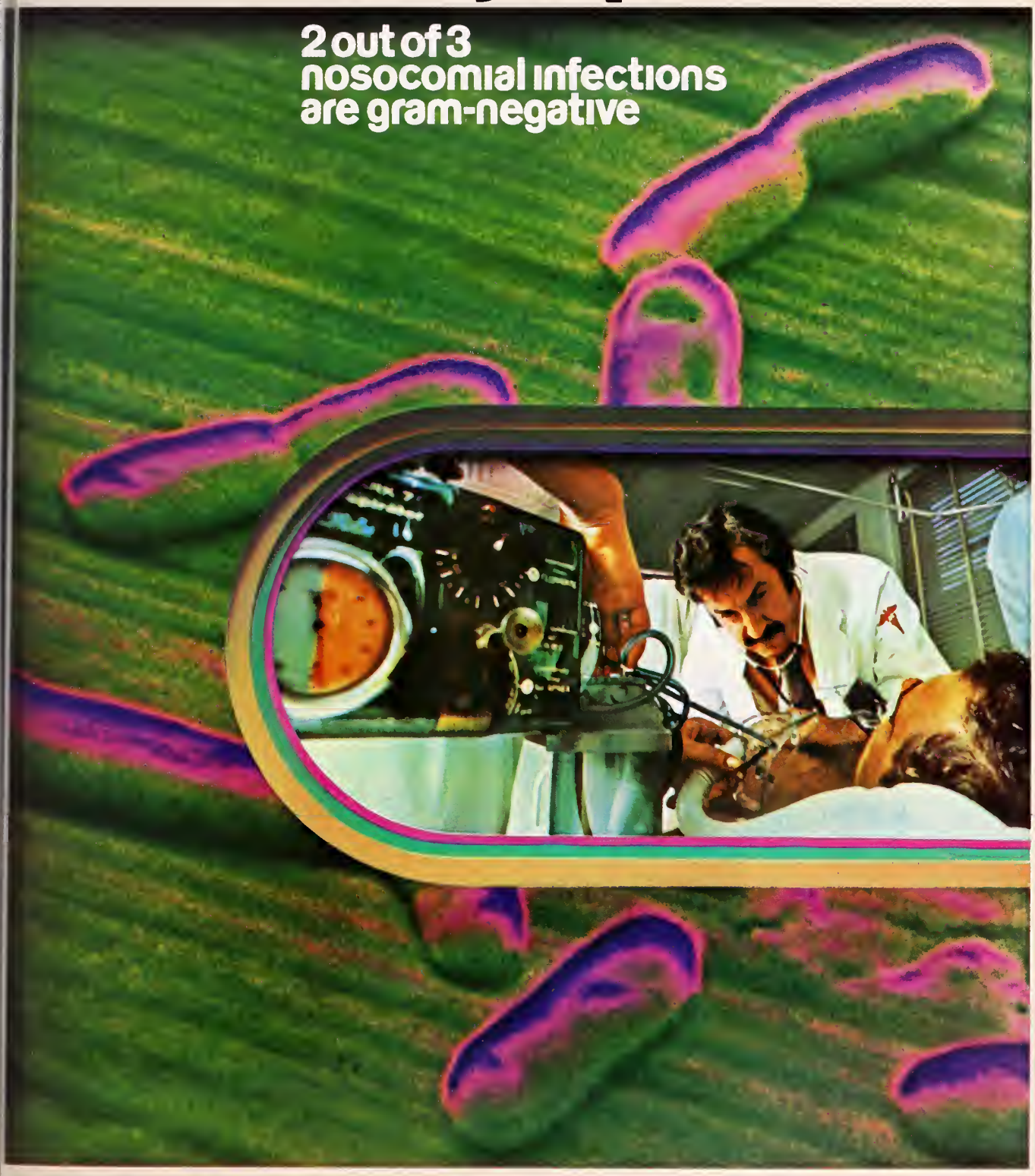
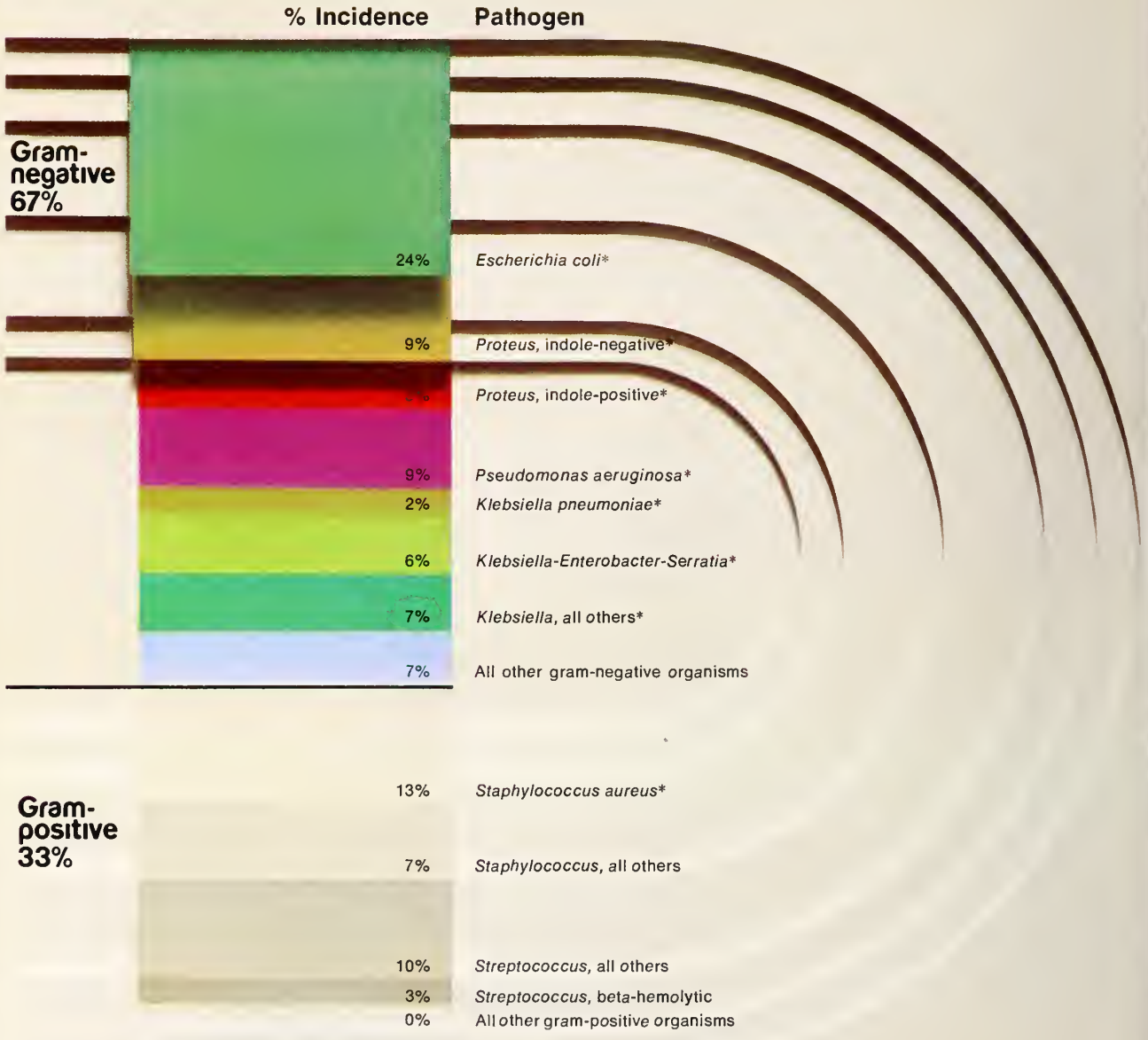
On all in-patient services... a major problem



Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective agains susceptible strains of the pathogens indicate

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A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella, *Enterobacter*, *Serratia* } species

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)*
*Due to susceptible organisms

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Schering

On all in-patient services...
in hospital-acquired gram-negative infections*

Garamycin®
gentamicin sulfate injectable
I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Also available:
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

GARAMYCIN® Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING
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USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

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Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

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Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

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The West Virginia Medical Journal

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Ureteroileostomy: A Review of 126 Cases

Stanley J. Kandzari, M. D.; D. Franklin Milam, M. D.; And Gerald A. Ravitz, M. D.

Ureteroileocutaneous anastomosis (Bricker's operation) is generally accepted as the best method of permanent cutaneous urinary diversion. Excellent reviews of collected experience with this operation have been written.[1-12] We will herein describe our experience with 126 patients who had this operation between 1960 and 1970 at West Virginia University Hospital.

The Authors

- **Stanley J. Kandzari, M. D.; D. Franklin Milam, M. D., and Gerald A. Ravitz, M. D., all in the Department of Surgery, Division of Urology, West Virginia University Medical Center, Morgantown.**

Indications

Malignant tumors were present in 78 patients and 48 patients had benign conditions. Cystectomy was performed at the same time with the urinary diversion in 54 patients with malignant tumors.

The indications for cutaneous diversion are illustrated in the following table:

Table 1

Indications for Ureteroileostomy

Carcinoma of the Bladder	51
Carcinoma of the Cervix	19
Intractable Stricture	11
Myelomeningocele	9
Spinal Cord Injury	8
Demyelinating Cerebral Disease	6
Neurogenic Bladder	6
Carcinoma of the Rectum	5
Exstrophy	5
Spina Bifida	3
Carcinoma of the Urethra	2
Carcinoma of the Prostate	1
Total	126

Technique

Preoperatively all patients received a clear liquid diet, laxatives and cleansing enemas but only 105 were given antibiotics.

A left paramedian incision is made. The appendix is excised and the terminal ileum is inspected and its mesentery examined by transillumination. A site for distal transection is selected approximately six inches proximal to the ileocecal junction. An ileal segment approximately 20 cm. in length usually is sufficient.

The area of section is identified and the bowel is divided in the midportion of this area between clamps. Bowel continuity is reestablished with a two-layer technique. In some cases, the anastomosis was done using a one-layer technique. The uretero intestinal anastomosis was routinely performed on the antimesenteric surface of the loop. Interrupted #4-0 chromic catgut sutures were used to anastomose the spatulated ureter to the full thickness of the bowel.

Temporary gastrostomy, after the manner of Stamm,[16] was done in 62 patients and nasogastric suction was applied in 64. We feel that temporary gastrostomy offers certain advantages over nasal suction such as:

1. The patient is more comfortable.
2. No pulmonary complications.
3. No failure of gastrostomy stoma to close within 48-72 hours.
4. More efficient gastric decompression due to larger lumen of tube.
5. No major postoperative complications.

Following the cystectomy, a #22F Foley catheter with a 150 cc. balloon was inserted through the urethra and left on traction for three to five days. This provides excellent drainage

and good hemostasis. It also is useful to detect any leak from the ureteral-ileal anastomosis.

Mortality Rate

There are 63 patients who have expired. Table 2 categorizes the number of patients dead, with their respective disease.

Table 2

Carcinoma of Bladder	36
Carcinoma of Cervix	14
Urethral Stricture with Pyelonephritis	3
Paraplegia with Pyelonephritis	3
Carcinoma of Rectum	3
Carcinoma of Urethra	2
Carcinoma of Prostate	1
Myelomeningocele with bilateral hydronephrosis	1
Total	63

There were 10 operative deaths with an operative mortality rate of 8.0 per cent. Table 3 shows the etiology of the 10 postoperative deaths.

Table 3
Postoperative Deaths

Extensive Terminal Carcinoma	3
Peritonitis 2° to ureteroileal leakage	3
Uremia	2
Pulmonary Embolism	1
Methotrexate Toxicity	1
Total	10

There were 11 anterior pelvic exenterations done, three for carcinoma of the urethra and eight for carcinoma of the cervix. Two patients who had an anterior exenteration for carcinoma of the cervix are living and well more than five years; the remainder are dead.

Four posterior pelvic exenterations were performed for carcinoma of the rectum invading the bladder and two patients are alive at five years.

Cystectomy was combined with urinary diversion as a one-stage procedure in 59 cases. Five cystectomies were done for benign disease and 54 for malignant disease.

Early Complications

Wound infection and prolonged ileus were the most common complications (Table 4). Preoperative use of an antibiotic bowel preparation did not seem to influence the incidence of wound infection.

Leakage at the ureteroileal anastomosis occurred in six patients. Five patients who had leakage of the anastomosis had long-standing neurogenic bladder disease with reflux and ureteritis. One patient with a ureteroileal leak had received preoperative irradiation for a bladder tumor. All patients with leakage at the anastomosis required surgical intervention, and three died postoperatively from peritonitis. An adequate blood supply with the minimal freeing of the ureter from its bed is essential in the production of a satisfactory ureteroileal anastomosis that will not leak. Also essential, is careful attention in the placing of a double layer of sutures.[5]

Wound dehiscence occurred infrequently and resulted in evisceration in one case. This unpleasant complication was encountered also by Cordonnier and Kaufman.[12]

Small bowel obstruction developed in four patients and three required surgical intervention, while one patient responded to conservative treatment. At exploration, adhesions were found to be the cause of the obstruction.

Pneumonitis developed in six patients, all of whom had been on nasogastric tube decompression.

A wide, unobstructed stoma is essential to a good functioning ileal loop. The presence of residual urine in the segment pre-disposes to infection and hyperchloremic acidosis. Periodic dilatation of the stoma is essential. Stomal stenosis, which developed in three patients was treated by simple revision with good results.

In most instances electrolyte imbalance was transient and represented mild acidosis which was treated medically.

Table 4
Early Complications

Wound Infections	15
Ileus	9
Wound Dehiscence	8
Pneumonitis	6
Leakage of Ureteroileal Anastomosis	6
Electrolyte Imbalance	5
Small Bowel Obstruction	4
Duodenal Stress Ulcer	3
Intestinal Fistula	2
Septicemia (Gram Negative)	2
Volvulus of Ileal Segment	1
Serum Hepatitis	1
Evisceration	1
Psychosis	1

Late Complications

Since we are dealing with dilated ureters and pre-existing infection, aggravation of pyelonephritis is bound to occur in some cases. Pyelonephritis occurred in nine patients, four of whom had preoperative symptoms. If there was no obstruction at the ureteroileal anastomosis, pyelonephritis always responded promptly to adequate antibiotic therapy. The presence of persistent pyelonephritis always suggests the possibility of poor mechanical drainage and careful upper tract evaluation should be made. The segment should be checked also to determine if there is any residual urine present.

The patency of the ureteroileal anastomosis is demonstrated by a careful gravity filled ileogram using 50 per cent hypaque. Five patients developed progressive hydronephrosis and were found to have ureteroileal anastomotic strictures. All five had to have their ureters reimplanted into the ileal loop.

Normally the nonobstructed bladder should empty completely, but often fluid collection results in empyema. Pyocystis with bacteremia developed in six patients where the bladder was not removed. Three patients with pyocystis had impassible posterior urethral strictures and suprapubic cystomy was performed. Three additional patients with neurogenic bladder disease were treated with indwelling urethral catheters. A foul fluid usually is obtained which has a positive culture for Escherichia coli.

The bladders were drained by an indwelling catheter and continuously irrigated with a solution of Neosporin mixed with saline. After control of the infection with antibiotics, cystectomy was performed in all six cases. A vesicovaginal fistula is created to prevent any accumulation of secretions in female patients according to the method of Spence.[15]

Table 5

Late Complications

Pyelonephritis	9
Mechanical Problems with Appliance	7
Pyocystis	6
Hydronephrosis	5
Acidosis	4
Renal Calculus	2
Stomal Stenosis	2
Small Bowel Obstruction	1
Incisional Hernia	1

Renal calculi occurred in two patients.

The incidence of intestinal obstruction was four per cent and is similar to the recent findings or Cordonnier.[5]

Surprisingly, few complications referable to skin irritation or the managing of the ileostomy bag have developed. Careful pre-discharge instructions in the management of the bag has prevented mechanical problems with the appliance.

Discussion

Ileal segments compare favorably with other methods of total urinary diversion. There is separation of the urinary and fecal stream and a decreased incidence of renal infection as compared with bilateral ureterosigmoidostomy. The short segment of ileum also offers a fast runoff with minimal amounts of residual urine, thus reducing absorption of urinary constituents.

A disadvantage of ureteroileostomy is a constant need for an external appliance.

Summary

One hundred twenty-six cases in which the ileal segment was used for urinary diversion are reviewed. Operative deaths, early and late postoperative complications, and their management are discussed.

This is a very useful method of permanent cutaneous urinary diversion. Increased experience with the operative procedure leads to improved results and better long-range prognosis.

A list of references may be obtained by writing The Journal.

Ah, summer, what power you have to make us suffer and like it.

Russell Baker

Review of One Year's Hip Fracture Experience In Huntington, West Virginia

Thomas F. Scott, M. D.

In the summer of 1970, I experienced, in my practice, a most serious complication following hip nailing, that is, a deep seated wound infection which eventually necessitated removal of the internal fixative device as well as the femoral head. Stimulated by this sad experience and the recollection that much of the time the Death and Complications Conference of the Orthopedic Section in Huntington dwelt on the complications of hip fractures, I initiated a retrospective review of the hip fractures cared for in the two large community hospitals in Huntington during the calendar year of 1971. The results in general from a demographic point of view confirm our impression and substantiate other similar reports.

We were able to locate and review the charts of 135 patients who were admitted to the hospital with fractures about the neck of the femur. These included 111 women constituting 82 per cent of the group and 24 men. The age span of the group ran from age 38 to 95. Interestingly enough, there were no fractures about the hip or the neck of the femur in children treated during this year. Demographically, 60 per cent of these patients were between the ages of 70 and 90 and 80 per cent were between the ages of 60 and 90.

One facet of the study demonstrated that the mean hospital stay of this group was 20 days but that in fully 37 per cent of cases the patient's stay exceeded 20 days. This is a raw figure and does not take into account the number transferred to an extended care facility or a small group who were returned to a state hospital facility for convalescence. This is of some interest to me in that 20 days seems to be the magic number selected by a Nationwide Medicare intermediary as being the optimal stay for patients with operative treatment of hip fractures. It would seem that many of these patients have underlying medical problems or superimposed postoperative complications which would prolong the stay beyond this golden figure.

Anatomic Location

The anatomic location of the fractures was divided almost evenly between intracapsular and and extracapsular. We were able to identify 30 subcapital fractures, 32 transcervical fractures, 66 intertrochanteric fractures and five subtrochanteric fractures.

The Author

- **Thomas F. Scott, M. D., Orthopedic Surgeon, 1611 13th Avenue, Huntington, West Virginia.**

Treatment

Treatment of this group of patients was carried out by the eight orthopedists of the city, seven of whom are board certified. The gamut of treatment extended from essentially no treatment whatsoever to femoral head prosthetic replacement. Two patients had no treatment, one apparently expiring prior to the institution of more definitive management. Three were treated in traction, primarily because of serious underlying medical problems such as cirrhosis, precluding operation. The great bulk of fractures were treated with open reduction and internal fixation utilizing Smith-Petersen nails, screws and side-plates, that is, 70 per cent or 94 were treated in this manner. Seven of the patients had the femoral head stabilized by multiple Knowle's pins. Twenty-nine were treated with femoral head prosthetic replacements, 11 of these being of the Thompson type and 18 of the Austin-Moore type.

I am wondering whether or not we "practiced what we preached." The charts were reviewed and a full 55 per cent of these patients received some form of antibiotic therapy during the course of their hospitalization. Although much comment in recent years has been made about the use of prophylactic anticoagulant therapy following hip nailing, 21 or roughly 15 per cent of this group received anticoagulant therapy sometime during the course of their hospitalization. In approximately one-third of the cases anticoagulant therapy was instituted only after a clinical demonstration of some form of thrombo-embolic phenomena.

Complications and Mortality

Seven patients died during the course of their hospitalization, a raw death rate of approximate-

ly five per cent. All seven deaths were basically attributed to some cardiopulmonary catastrophe. Three of the patients were reported to have wound infections, with an infection rate somewhere around two and one-half per cent. Two of these infections, incidentally, were in Austin-Moore prostheses inserted in the summer months in almost consecutive cases. At this point the plastic carrying case utilized for the autoclaving of the prosthesis was cultured; no growth was found. Four cases with thrombophlebitis were reported, with two pulmonary infarctions. Some form of pneumonitis developed in three cases; two other pulmonary complications were reported, including atelectasis. Two cardiac complications were reported including a coronary thrombosis. Decubiti were reported to have occurred in two cases during the course of hospitalization; this does not include, however, the evidence of skin breakdown over the heel or Achilles' tendon of patients mobilized with Buck's traction. Urinary tract infections were reported in five cases; these apparently were of some clinical significance as the high majority of these patients had indwelling catheters during the course of postoperative convalescence. Two cases of bleeding gastric ulcer were reported, which was somewhat of a surprise.

Complications due to operative technique were surprisingly low in that we note a Smith-Petersen nail was cut out of the head and neck of the femur of a single patient who had Parkinson's disease which was not controlled even with the best of medical management available. There was one case reported of dislocation of a femoral head prosthesis; this is of some interest to me in that dislocation of prostheses was feared and guarded against rather stringently in the not-so-recent past, even to the point of mobilizing many of the patients in abduction boots which was not routinely done in any of this group.

Summary

In summary, we have a significant number of fractures treated by varying orthopedic surgeons but utilizing rather similar techniques. Aside from my own personal group of wound infections, the infection rate and death rate correlate well with previous reports of this nature. Of course, due to the nature of the present study, this does not in any way evaluate the long-term results or follow-up on these patients as to their function or rate of bone healing but only the result of the patient's ability to survive the insult of operative treatment and being in the foreign environment of a hospital during physical and emotional stress.

Monkeypox: A Not So Funny Disease

MONKEYPOX, a serious, widespread disease among sub-human primates, can be contacted by humans. This virus is virtually indistinguishable from smallpox. Fortunately, the only known infecting sources are ill monkeys and apes. There is no known case of human-to-human transfer.

Dr. Von Magnus, in Copenhagen, first identified the virus during an outbreak of vesicular disease (characterized by blisters on the skin) among captive primates. Further investigation by Doctor Von Magnus revealed that this virus is quite common among the primates in Europe and North America. There is no vaccine available for Monkeypox Disease. Having the disease or being vaccinated with variola vaccine does not bestow immunity to Monkeypox Virus.

The search for diseases of animals similiar or identical to those occurring in man continues to occupy an important place in medical research, according to the National Society for Medical Research.

Special Article

The Future of Family Practice*

James L. Grobe, M. D.

FIRST, I should apologize. I've been asked to discuss with you "The Future of Family Practice" and I've come away without my crystal ball, or even tea leaves or an ouija board.

Seriously, I wouldn't know what to do with a crystal ball if I had one — unless I used it as a paperweight. But I *can* talk about the *future* of family practice because I'm so well-acquainted with its *past*. And its' easy to see from the growth the family practice movement has enjoyed in just the last five years that the future contains tremendous potential for the specialty's growth and expansion.

But before I launch into a discussion of family practice and the family doctor's expanding role in meeting the nation's health care needs, I'd like to review the past so we'll know where we stand now and what it took to get there.

In 1930, nearly all practicing doctors styled themselves "general practitioners," the basic classification for the type of doctor who took care of the health needs of the people. Medical school by then was thoroughly modernized along Flexner guidelines but graduate education was largely confined to the internship, considered to be sufficient "on-the-job" training to take care of most ailments. Specialists were few and generally found on medical school teaching staffs.

The depression did nothing to change this, but then came World War II and its total commitment to victory. The wartime government expedited (a favorite word of the time) medical mobilization by categorizing everything in terms of specialties. Deferments were even offered to young doctors agreeing to enter the many new specialty residencies created to receive them.

With the war over, a whole new dimension was added to medicine — the highly trained specialist in a medical climate where the demand was for primary care. The neat G.I. categories gave way to the less highly structured civilian society. But, people being people, the public became enamored of the surge of research and discovery following the war, and the practice of having a specialist do a non-specialty job caught on and burgeoned.

Eyeing the higher intra-professional status accorded the specialist, and perhaps the higher fees, young physicians continued to flock into graduate programs.

AAGP Founded in 1947

Amid the swirl of specialism, the American Academy of General Practice was founded — in

The Author

- **James L. Grobe, M. D., Phoenix, Arizona; President, American Academy of Family Physicians.**

James L. Grobe, M. D.

*Presented during the 21st Annual Meeting of the West Virginia Chapter, American Academy of Family Physicians, April 6-8, 1973, at Lakeview Inn and Country Club, Morgantown.

1947 — in an effort to preserve the concept of general medicine. The founders hit on the idea of demanding that its members satisfy continuing education requirements; thus, the Academy in effect became a certifying organ within itself. The AAGP grew as its preservative purpose became clear to the nation's general practitioners. By 1960 it had almost 30,000 members and had reached a pinnacle of organizational prestige, ranking in size, and to some degree influence, second only to the American Medical Association.

But powerful as the Academy was, there were basic problems that remained unsolved and the storm warnings were up. For example, the problem of surgery had not been solved — general practice surgeons controlled the organization and saw no reason why G.P.'s shouldn't do all the surgery they wanted to. True, many of these doctors were highly qualified to do any procedure they wished. But, the absence of a single controlling factor made for confusion in medicine's ranks, a confusion that worked to the detriment of attempts to recruit young doctors to general practice.

Although the Academy made repeated attempts to obtain a certifying mechanism, it met nothing but failure until 1966, when a catalyst was dropped in the form of four reports published in a span of 100 days — all proposing creation of a family practice specialty.

Reports of Folsom and Millis Commissions

The report of the National Commission on Community Health Services, also known as the Folsom Commission, stressed the need for every individual to have a personal physician to provide easy access to health care on a coordinated, comprehensive and continuing basis. This physician would be skilled in preventive medicine and the use of community resources.

The report of the Citizens Commission on Graduate Medical Education, the Millis Commission, called for a similar physician, but labeled him a "primacy" physician. It emphasized the crucial importance of comprehensive health care, and decried the apparent lack of medical school interest in this area.

The report of the Ad Hoc Committee on Education for Family Practice of the AMA Council on Medical Education, the Willard Report, called the new specialist in comprehensive health care the "Family Physician." The Committee recognized the need for "significant reorientation of medical education and change in the attitudes of the medical profession."

It asserted that family practice should be accorded specialty status because the family physician's composite body of knowledge and his function are significantly different from other specialists.

The fourth report of 1966 which provided impetus to the new specialty was that of the AAGP Committee on Requirements for Certification. This committee formulated the core content of family practice, which was to serve as the foundation for future residency programs.

Certifying Board Approved

Accordingly, in 1967, the Academy made a formal application to the Advisory Board for Medical Specialties for creation of a certifying board. This request was not approved but the petitioners were asked to submit another application and to revise guidelines for residency training. The application and revised guidelines were resubmitted and on February 8, 1969, a Certifying Board in Family Practice was approved.

The Board was organized during the Summer and Fall, and the first certifying examinations were held February 28-March 1, 1970 in 36 centers across the Nation. Since then, two other examinations have been held and a fourth will be held in October, 1973. To date, 4,500 family doctors are classified as Diplomates of the American Board of Family Practice. All have passed the examination. There are no "grandfathers," and all Diplomates must be recertified after six years. Family medicine is the only specialty requiring this recertification — but we have a feeling it won't be long before the other boards will insert similar "teeth" in their provisions for continuing competency.

Eligibility to Take Certifying Examination

There now are two avenues for attaining eligibility to take the certifying examination in family medicine — the practice-eligible route and the residency-eligible route. The practice-eligible route, used by most of today's diplomates, is based on satisfaction of continuing education requirements of the AAFP — six years or 300 hours of approved study. After 1978, only the residency-eligible category will be retained. By that time we are confident we will have a minimum of 1,000 graduating residents each year. The AAFP's total educational approach — undergraduate, graduate and continuing — is geared to helping produce more certified family physicians. This continuing education function, the Academy's hole-card, has provided the foundation for the new specialty. It will be the key to recertifi-

cation of these diplomates as well as those who later emerge from residencies.

New residency programs are being started in university medical centers and teaching hospitals across the Nation. At this moment there are 150 programs approved by the Residency Review Committee for Family Practice, a joint organ of the AMA Council on Medical Education, the AMA Section of Family/General Practice, and the AAFP. There are more than 1,500 residents in these programs, with at least 250 more, conservatively, expected in July.

Where Are We Now?

This, then, is a little of the history of family medicine. It's where we've been. But where are we now?

While it's true that family medicine has its foundation in general practice as we knew it, it takes a different tack from the very beginning. The very emphasis is different.

Where general practice focused on the *medical crisis*, the approach of family medicine is on *health maintenance*.

Where general practice *might* incorporate family and community relationship factors into the diagnostic and therapeutic mix, family medicine is geared *precisely* to this approach.

Where continuity of care was a desirable fea- of general practice, *it is a must in family medicine*.

Family Practice Unit

The workshop for honing the special functions and attitudes that characterize the specialist in family medicine is the model family practice unit, the focus of the family medicine residency. The model unit approximates an office practice situation. In it, the resident serves as the family doctor for a group of families, following them through the three-year period. In the unit he learns not only the clinical aspects of caring for families but also is constantly exposed to the mechanical and financial problems that doctors confront in the everyday practice of medicine. It is clear that one facet of the doctor shortage — one never mentioned by medical or political leaders — is inefficient practice methods. This is a pervasive problem, one that is only beginning to be recognized by medical schools. The people responsible for family practice training — the AAFP, the AMA Council, the Section — have recognized the problem, understand its implications, and are confronting it on the educational level with high quality model family practice units.

For all their "zeroing in" on the right problems and asking the right questions, it is amply clear that family practice residencies are still in the development stage. For example, much needs to be learned about preventive health care, the most effective modalities in health maintenance, the most effective utilization of community health and welfare source, etc.

The model family practice unit then is not just a workshop but a laboratory, where challenges every bit as exciting as benchwork in virology, atomic medicine, etc., are being confronted and worked out. I certainly do not mean to put down the importance of benchwork research in medicine. It is vital and must continue unabated. But it is also vital that important attention be given to research in the delivery of health care. The spearhead of this effort is the family medicine residency.

Education: An Expensive Item

Education is expensive, and any kind of truly new educational form is terribly expensive. For this reason, federal funds were sought soon after the guidelines for graduate training programs in family medicine were approved. Legislation was written and polished, then approved by the Congress overwhelmingly. Then, incredibly, it was pocket vetoed by President Nixon. Right or wrong, the veto stood and we and our AMA colleagues had to go back to Washington. As you know, the Comprehensive Health Manpower Act of 1971 was approved, and funding made available $5 million for family medicine residencies. We didn't get as much as we needed but it was a start.

One of the most important upshots of the frustrating experience in Washington was the fact that new residencies continued to be formed and new residents came to fill them despite the Administration's attempts to block the flow of federal funds into this area of medical education. This said volumes to us. It meant we had a thing of value that appealed to young physicians coming out of medical school.

Role of the Medical School

This is where family practice stands on the graduate and postgraduate levels. Now, what about medical school, where it all begins?

At the close of 1972 there were 66 full departments or divisions of family medicine in U.S. medical schools. Twelve others were in various stages of development. Undergraduate interest appears to be running very high, and we seem to be gaining heavily in the third and fourth years, a departure from tradition in which the drift toward consultative specialties took hold in the latter years of medical school. Student affiliate memberships in the Academy are at an all-time

high, which means not only that undergraduate students are more interested than before, but also that the AAFP state chapters have increased their activity in this area.

Future of Family Practice

Given this background, I think it would be interesting to discuss now the *future* of family practice.

I must be honest from the start. To my mind, the future of the nation's health care and the future of family practice are incontrovertibly linked. I see achieving primary health care on any kind of comprehensive, pervasive basis as dependent on the restoration of the primacy of the family physician, to function with the patient and his family on a one-to-one continuing basis. Put another way, I feel that family practice holds the greatest potential for meeting and improving the problems currently facing the nation's health care delivery system.

Having grown up professionally in the so-called Age of Specialization, nobody is more aware than I that any return of the family doctor on the basis I'm talking about would have been impossible just five years ago. But that is changed now. Since creation of the ABFP, the climate for the resurgence of family medicine has grown more and more favorable.

New Blood in the Profession

But the catalyst for this return to primacy that I'm talking about is you, the young physicians and medical students. The best thing that has happened to American medicine in the past few years is the transfusion of new blood that is now beginning to flow into the profession, with different ideas but, much more important, a dedication to service to people.

Happily for family medicine, its focus is on the very people — as people — that the youth of today are turned on to in its emphasis on life instead of structure, personal value instead of the sanctity of the system. The emerging attitude among medical students today is that health care must be taken to the people, wherever they are found, and not that health care is a commodity that is shut up in an institution that dares the people to get it.

Competence Demanded

At the same time that today's young doctors are ready to mount the barricades in behalf of the people, they also are demanding greater provable competence of themselves and their colleagues than ever before. I remind myself and my colleagues to make no mistake: youth will not accept the cover-ups, the mantles of immunity, and the sanctimonious "above-the-law" attitudes that have sometimes crept into the medical establishment in the past. *And that goes in spades for the family physician.* In the past, it was expected that everybody would love "good old Doc" and it was as often accepted that he wasn't much when it came to the latest in treatment. That won't do anymore. The youngsters are willing to give their allegiance to family health care but they absolutely demand that the quality of training and the quality of care it generates must meet and even exceed the highest standards applicable to the rest of medicine. This is what the specialty of family medicine is all about.

Crystal ball or not, no one can "foresee" the future. We can, however, see current trends and project their impact. For instance, one "vital sign" we must take into account now in our plans for the future is an important change in the character of illness itself.

Care of Chronic Illnesses

Whereas in the not-so-distant past, most patients died from acute infectious diseases, today's chief causes of death are chronic illnesses. The major killers — heart disease, vascular problems of all kinds, and cancer — have a course which can extend over years.

Medical care must increasingly be delivered in an office setting to ambulatory patients with these chronic illnesses who need help during the phase in which the illness is passing. Hospitalization is usually only an episode in long-term care which results from an acute complication or a terminal event.

Many other symptoms presented stem from the stress of living and working in the highly competitive society of today. We can expect the frustrations and conflicts which arise as a result to increase in the future as industry becomes more impersonalized and procedures more mechanical. The practicing physician will come to spend about half his time in caring for functional overlay and problems of adjustment to illness and stress.

As Alvin Toffler so aptly demonstrates in his book *Future Shock*, change carries a high physiological price tag with it and can exert a recognizable influence on health. It is one of the book's tenets "that the health of the individual is intimately bound up with the adaptive demands placed on him by the environment" and that change itself — not this or that specific change but the general *rate of change* in a person's life —

could be one of the most important factors in his health. Since we live in a time of almost constant change, the demand for something stable in our environment increases. Thus, the tremendous demands for a family doctor willing to assume the responsibility for the supervision of his patients' total health care needs, willing to accept the burden of providing continuous and comprehensive health care, willing to be as interested in *keeping* us healthy as in *getting* us healthy.

So ultimately, the "future of family practice" is the residents and medical students of today because of the vast potential they represent in terms of compassion, concern and opportunity.

The author of *The Making of a Counter Culture*, Theodore Roszak, puts it this way: "It is at the level of youth that significant social criticism now looks for a responsive hearing as, more and more, it grows to be the common expectation that the young should be those who act, who make things happen, who take the risks, who generally provide the ginger."

'Gifts of the Young'

Charles Reich, author of *The Greening of America*, echoes this thought by saying: "One of the gifts of the young is to see through phoniness and cant . . . . It is the notion of personal responsibility which *makes* the new generation."

From visiting with medical students, interns and residents, I am sure that they are the type of people to whom I have just alluded. They know that being a good family doctor requires a unique combination of interests and aptitudes. They fully understand that not everyone is capable of being family physicians and that family medicine is not the right specialty for every newly graduated M.D.

Medical students realize that family doctors must have the ability to see the "big picture," to see the patients as a member of his family, and of his community and to treat him in this context, to see his medical problems in relation to his other problems, to see the "man behind the invalid." Also, family physicians must be able to filter the important from the trivial and to make rapid, reasonable and accurate value judgments.

Faced with these great challenges of family medicine, and the opportunity of really getting involved with people, today's students are opting for family medicine.

They are the future of my specialty, and ultimately of my profession.

I am supremely confident that my faith and belief in these young people is justified and that the future of family medicine is unlimited, and is in capable hands.

Good-humor makes all things tolerable.

HENRY WARD BEECHER

Aunt Sarah, I love you.

Remember my 10th birthday, when you gave me that funny piece of green paper and everybody made such a fuss over it. (Except me.) Frankly, it was a pretty disappointing present for a kid. I couldn't eat it, couldn't play with it, couldn't wear it—and Mom took it away from me practically the minute I got it.

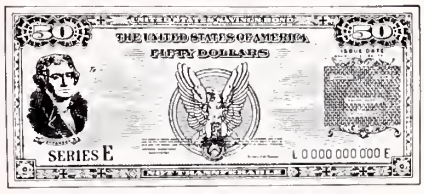
And every birthday after that (and Christmas, too), you gave me another one of those *Bonds*, you called them. I thought you were pretty gooney.

At least, I never had to guess what I was going to get from good old reliable Aunt Sarah.

And what I got was good old reliable U.S. Savings Bonds.

What I didn't realize then was that you gave me a gift of security for the future. Thanks to you and those Bonds, I had extra funds for college. And they helped when I bought my first new car.

Next week, I'm giving my nephew, Harry, his first U.S. Savings Bond. I know the kid is gonna think I'm some kind of nut. But, someday . . .



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Special Article

Developments in Family Practice at The WVU School of Medicine*

Clark K. Sleeth, M. D.

YOUR President, Dr. Richard E. Flood, has asked that I present a brief summary of recent and current developments at the West Virginia University School of Medicine with regard to an educational program for Family Practice. I appreciate the opportunity to provide a brief and factual statement in this regard.

General Background

First, a very brief bit of general background may be in order. During the period from about 1900 to the mid-1930's professional and public concern with the *quality* of medical education, best expressed in the "Flexner Report," led to the voluntary closing of many marginal or substandard "schools" and to the upgrading of others. The years following World War II saw the development of more schools of medicine, and the expansion of existing ones, a trend continuing until very recently, with acceleration in the past decade. Even so, there has been increasing public expression of concern about the "doctor shortage," and more especially about the shortage of family physicians.

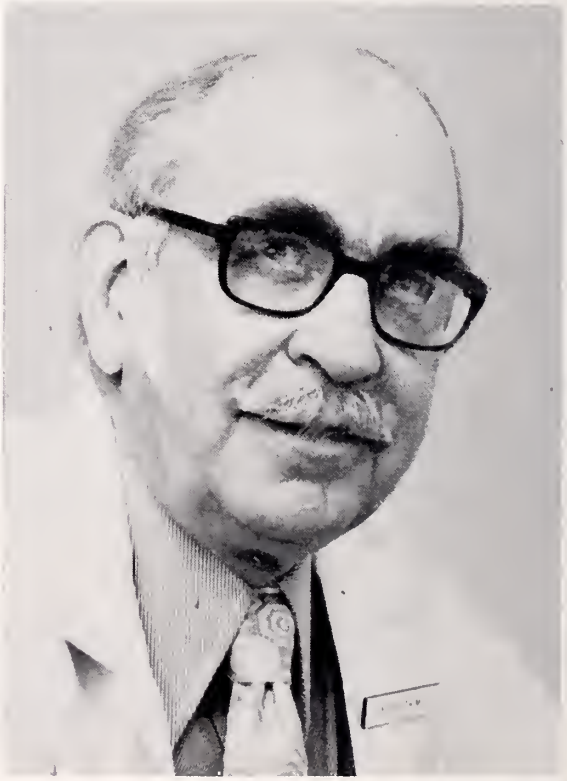
During the past five or so decades the "knowledge explosion," particularly in science and technology but also present in other fields, has created so much new knowledge, so many new skills and techniques that the "age of specialization" was apparently inevitable. Specialization has occurred in fields other than the healing arts — for example law, engineering, even the clergy, but perhaps nowhere to a more marked degree than in Medicine.

The decades since the '20s have seen an increasing proportion of medical graduates elect to secure advanced training and certification in one or another of the ever-increasing variety of specialties. Schools of Medicine have been identified as *the* "culprit" in this trend, but reflection will show that the trend stems from no *single* source.

The Author

- **Clark K. Sleeth, M. D., Acting Chairman, Department of Family Practice, West Virginia University School of Medicine, Morgantown.**

Increased recognition is accorded the specialist in the form of hospital staff privileges. Often he can have improved regularity of working hours. His earnings have generally exceeded those of the family physician. *Public knowledge and interest* has often led the patient to by-pass the generalist and apply directly to the specialist for care. The importance of *this* stimulus to specialization is often not well recognized.



Clark K. Sleeth, M. D.

*Presented during the 21st Annual Meeting of the West Virginia Chapter, American Academy of Family Physicians, April 6-8, 1973, at the Lakeview Inn and Country Club, Morgantown.

Perhaps most important of all has been the specialist's own feeling of security in his ability to encompass the pertinent knowledge and skills in a specialty to a degree which *he perceived* to be impossible if attempted across the entire spectrum of medicine.

Whatever the reasons, the net result has been a reduction in the relative proportion and even in the absolute numbers of physicians available to the public as "general practitioners," "family physicians," "primary care physicians" or whatever name one wishes to apply.

Increasing Need for Family Physicians

During the decade of the '60s increasing public concern with the difficulty of access to a family physician became manifest in many ways. The report of the "Millis Commission" called for increased numbers of "primary" physicians and for recognition of this type of practice as a specialty. Various elected legislative bodies expressed similar concerns in a variety of ways and the Medical Profession, through the American Medical Association, in 1969 extended formal recognition to the American Board of Family Practice.

The situation in West Virginia has in most ways been parallel to that in the country generally. Relatively speaking, it is probable that a greater proportion of West Virginians have continued to enjoy access to a family physician for a few years longer than has been the case in many parts of the country. The general trend, and the public and professional concerns have, however, resembled the national trend more than they have differed from it.

Activities Underway at WVU

With this outlined background let us consider what activity has been underway at the West Virginia University School of Medicine in relation to developing a program of education and training for the specialty of Family Practice or Family Medicine.

Early in 1971 the Dean of the School appointed an *ad hoc* committee composed of faculty members, house officers and students who conducted a thorough review of many factors, including (1) existing programs of education and training, their successes and failures and the reasons therefor; (2) their organization and financing; (3) their curricular organization both undergraduate and graduate; (4) the conditions under which a program could receive accreditation; and (5) the requirements imposed upon the individual seeking certification by the certifying board. It is of more than passing note that of the six faculty representatives on this committee a majority had been engaged at one time or another in the General Practice of Medicine.

While the work of this committee was still in progress and even before the submittal of their final report the Dean of the School of Medicine prepared an application for financial support which was submitted to the Bureau of Health Manpower Education, National Institutes of Health of the Federal Department of Health, Education and Welfare. This application described a program in conformity with the principles established by the professional organizations whose approval of the program would be necessary, namely the American Academy of Family Practice and the American Board of Family Practice.

The application was forwarded to the granting agency in the Fall of 1971. The response from the granting agency was that Federal financial aid was limited to support of programs of preceptorship only.

School Moves Ahead With Plans

Disappointed but undeterred by the failure to receive Federal aid in funding the proposed program the School continued to plan and after careful study and deliberation the special committee submitted a detailed report embodying a series of some 19 recommendations, chief of which was that the School should establish a program in Family Medicine, and including such further detailed recommendations as that the program should be accorded full departmental status; that the director and faculty members be employed on the same full-time basis as other faculty, and the like. The report was reviewed and approved by the appropriate groups which included the following: The Executive Faculty of the School of Medicine; the Faculty of the School of Medicine; the Faculty Senate of the University and the appropriate administrative officers of the University.

With these endorsements a formal proposal for establishment of a new department, conducting a new program, was forwarded to the State Board of Regents for Higher Education, without whose prior approval no new program may be undertaken by any institution under their purview.

On April 11, 1972, the West Virginia Board of Regents acted to approve the proposed program.

Search for Chairman of Department

At that point in development, the Dean of the School of Medicine appointed a committee to search for the best qualified, available person to

accept the chairmanship of the new department. That committee consists of representatives of the faculty, the housestaff, the student body and includes a respected Past President of the West Virginia Chapter of the AAFP. This group has worked diligently during the past year, has met on numerous occasions, has corresponded with a number of persons to solicit their suggestions as nominees for the position, has received and reviewed the credentials of a number of potential candidates and has conducted interviews with at least four qualified physicians who have been sufficiently interested to visit the school. As of February 1, 1973, none of the persons to whom the position was offered had elected to accept. Reluctance to leave a program which was still in relatively early stages of development was a factor in some of these individual decisions.

A most important element in any program of education and training in any branch of medicine is the actual operation of a program providing patient care of the kind concerned. In the case of Family Medicine, the American Board of Family Practice has formulated some very specific (one can say unusually specific) requirements regarding the design of the facility, the patient population to be served and the program to be conducted. Under ideal circumstances the chairman of a new department (i.e. the director of a new program) should have considerable individual input into the design of the facility in which he must work, and the program which he must conduct. The specificity of the imposed requirements, however, is such as to limit individual initiative to a considerable extent in both these areas, and provided the opportunity for the School to move forward even before a Department Chairman could be named.

Responsibilities of the Acting Chairman

Under such circumstances, and in the interest of expediting progress, an institutional decision was made to request your present speaker to undertake the responsibilities of moving ahead with specifications for the design of a clinic facility (a "Model Family Practice Unit") which must be created; with the basic description of a program to be conducted to meet the requirements of the accrediting agency; with the formulation of an application for approval by the accrediting agency, and, as a member of the search committee, to assist in the recruitment of a permanent chairman and other faculty members for the department.

After considerable deliberation, I agreed to accept the proferred responsibility, motivated, I believe, by a sincere desire to see the program move ahead with a minimum of delay. Let us recall that even in the event a permanent chairman should accept an offer tomorrow it would surely be a matter of some months before he could be "on the ground" to *begin* the work, which, under the present arrangement, already is underway.

During the approximately two months since my appointment facilities design has progressed to a point at which conferences are being held involving an architect and administrative officers of the Medical Center. Program design is similarly progressing and the application for program approval is in preparation. I will not bore you with the details of the 20-page application with which some of you already are acquainted. However, there are certain additional constraints surrounding the approval process. The accrediting board meets three times annually for review of applications — in January, May and August. The application, which among other detail must include a scale diagram of the facility, must be postmarked 10 weeks in advance of the meeting of the board. In this connection, it might be noted that after the architect's drawings are found to meet the needs foreseen by the local planners, it is not possible to proceed with alteration of a State-owned structure without prior approval of the appropriate State agency, in this case the Board of Regents.

West Virginia University School of Medicine continues to be committed to the conduct of a program in Family Practice, and will proceed with implementation as rapidly as is possible, consonant with meeting the requirements of the various professional and public agencies concerned, and contingent upon the availability of the fiscal resources for such a program.

Spirit of Mutual Cooperation Needed

While one can understand the impatience of those who are conscientiously concerned with present needs, it is my own conviction that productive activity in pursuit of our common goal depends upon a spirit of mutual cooperation. I believe such is in evidence by the presence of a member of this Academy upon the School's Committee to search for a Chairman, and by the recent action of the House of Delegates of this Academy urging fiscal support of the Department of Family Practice by the Legislature.

It is in this spirit of mutual cooperation that I have tried to place before you this factual summary.

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INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

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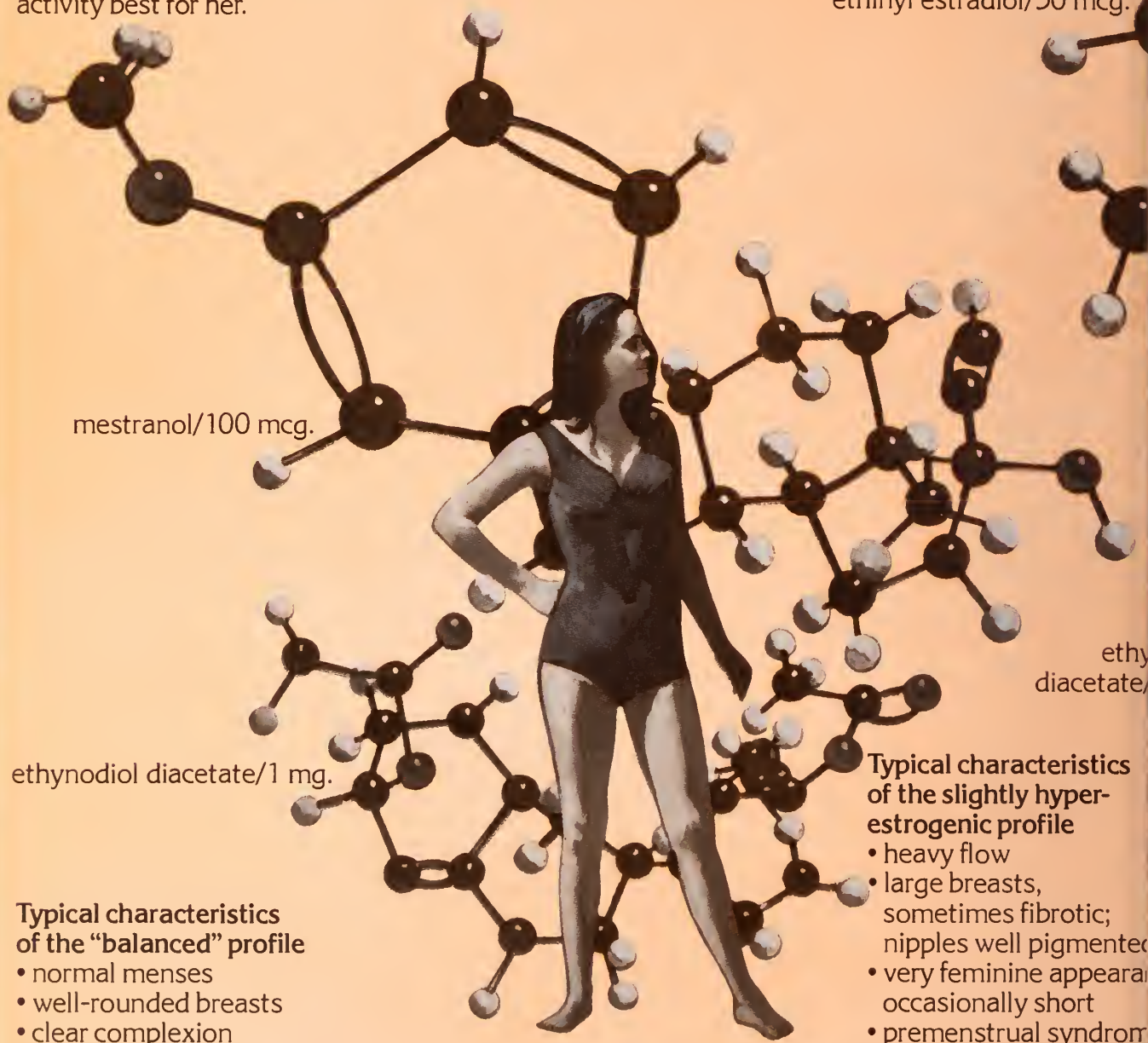

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Typical characteristics of the "balanced" profile

- normal menses
- well-rounded breasts
- clear complexion
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This "center spectrum" pill has had excellent user acceptance for over seven years.

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Available in 20-, 21- and 28-pill schedules
Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.
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for the majority of women... when centrally balanced activity is preferred

Typical characteristics of the slightly hyperestrogenic profile

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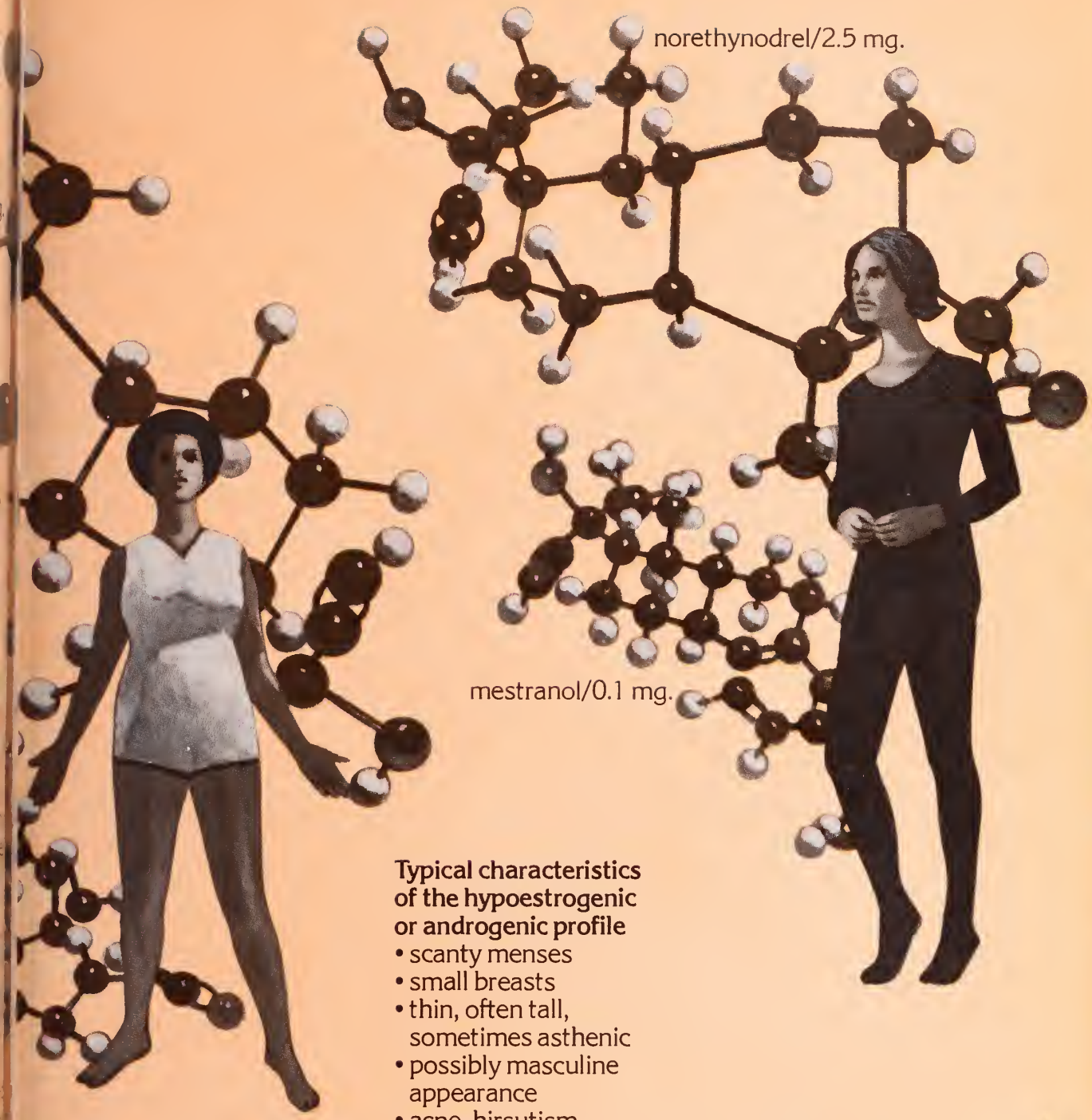
- very feminine appearan occasionally short
- premenstrual syndrom fluid retention
- tendency to uterine fibroids
- high pyknotic index

This formulation, which a less estrogenic activity a a moderate progestoger dominance, may be a go beginning.

For brief summary of prescribing information, please see next page.



Typical characteristics of the hypoestrogenic or androgenic profile

- scanty menses
- small breasts
- thin, often tall, sometimes asthenic
- possibly masculine appearance
- acne, hirsutism
- low sexual motivation
- thin vaginal lining, tendency to vaginitis and dyspareunia

This pill has a relatively weak and unique* progestogen with inherent estrogenicity. Clinically, just as in animal studies, it appears not to possess antiestrogenic and androgenic activity.

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ıen low estrogenic activity
ıd moderate progestogen
ominance are preferred

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Available in 20- and 21-pill schedules
Each tablet contains: norethynodrel 2 5 mg./mestranol 0.1 mg.

a clear choice for women when estrogen dominance and no androgenic activity are preferred

*Of all the progestogens, norethynodrel most resembles the molecular structure of the estrogens. It has the weakest progestational activity of any progestogen in a combination pill.

Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen-28® is a placebo, containing no active ingredients.

Actions — Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note — Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication — Ovulen and Demulen are indicated for oral contraception.

Contraindications — Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings — The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions — The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovar adrenal, hepatic or uterine function awaits further study. A decreas glucose tolerance has been observed in a significant percentag patients on oral contraceptives. The mechanism of this decreas obscure. For this reason, diabetic patients should be carefully obser while receiving Ovulen or Demulen therapy. The age of the patient stitutes no absolute limiting factor, although treatment with Ovule Demulen may mask the onset of the climacteric. The pathologist sh be advised of Ovulen or Demulen therapy when relevant specim are submitted. Susceptible women may experience an increas blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives — A statistically significant association has been demonstrated between use of oral contraceptives and the following ser adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, suc relationship has been neither confirmed nor refuted for the follov serious adverse reactions: neuro-ocular lesions, e.g., retinal thr bosis and optic neuritis.

The following adverse reactions are known to occur in pati receiving oral contraceptives: nausea, vomiting, gastrointestinal sy toms (such as abdominal cramps and bloating), breakthrough bleed spotting, change in menstrual flow, amenorrhea during and after tr ment, edema, chloasma or melasma, breast changes (tendern enlargement and secretion), change in weight (increase or decrea changes in cervical erosion and cervical secretions, suppressio lactation when given immediately post partum, cholestatic jaund migraine, rash (allergic), rise in blood pressure in susceptible individ and mental depression.

Although the following adverse reactions have been reported users of oral contraceptives, an association has been neither firmed nor refuted: anovulation post treatment, premenstrual syndrome, changes in libido, changes in appetite, cystitis-like syndro headache, nervousness, dizziness, fatigue, backache, hirsutism, los scalp hair, erythema multiforme, erythema nodosum, hemorrh eruption and itching.

The following laboratory results may be altered by the use of contraceptives: hepatic function: increased sulfobromophthalein re tion and other tests; coagulation tests: increase in prothrombin, Fac VII, VIII, IX and X; thyroid function: increase in PBI and butanol extr able protein bound iodine, and decrease in T^3 uptake values; metyrap test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral C traception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:2 279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigatio Deaths from Pulmonary, Coronary, and Cerebral Thrombosis Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193- (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relat Between Use of Oral Contraceptives and Thromboembolic Disease Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartw P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Throm embolism and Oral Contraceptives: An Epidemiologic Case-Con Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions — Enovid-E acts to prevent ovulation by inhibiting the put of gonadotropins from the pituitary gland. Enovid-E depresses output of both the follicle-stimulating hormone (FSH) and the lut izing hormone (LH).

Indication — Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* a *Adverse Reactions* listed above for Ovulen and Demulen are applica to Enovid-E and should be observed when prescribing Enovid-E.

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Where "The Pill" Began

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

WEST VIRGINIA DIVISION, INC.
325 Professional Building
Charleston, West Virginia

THIS SPACE CONTRIBUTED BY THE PUBLISHER AS A PUBLIC SERVICE

A message from . . .

The President

THE FOUNDATION AND PSRO

After several years of discussion all physicians in West Virginia should know that a Medical Foundation is not a ladies' undergarment or the underpinning of a building.

A Foundation for Medical Care is an organization of physicians sponsored by a medical society. Many states and counties have sponsored such corporations to deal with the myriad problems that the medical societies cannot handle directly.

Most Foundations endorse:

1. Adequate medical care at a cost reasonable for patient and provider.
2. Quality care in any and all facilities used for health care delivery.
3. Freedom of choice for patient and physician.
4. Evaluation and review of quantity and quality of medical care by medical peers.
5. Cooperation with third party payors—private and government—to assure periodic and realistic budgeting for medical care.

The recent enactment of Public Law 92-603 mandating professional standard review organizations (PSRO) has prompted many medical organizations to form and activate foundations to handle the review of the inpatient hospital care under government sponsored health programs — Medicare and Medicaid. Other third party payors can and should avail themselves of this peer review mechanism to determine reasonable cost, utilization and quality of health care. All physicians licensed to practice medicine must be eligible for membership in an approved PSRO.

Criteria for diagnosis and treatment for all disease entities must be defined by physicians as guidelines for peer review. The use of and the guidelines by participating physicians can be a medical learning experience and the guidelines must be modified with experience. Allied medical personnel can assist in many activities, but the physician must be the final authority in peer review. The magnitude of the problem may make computer capability essential in a program.

The Ad Hoc Committee on Foundations of the State Medical Association has completed a draft of the proposed Foundation for Medical Care for West Virginia. We hope that this Foundation can be the vehicle for PSRO, third party negotiation and continuing medical education for the physician in West Virginia. This draft has been distributed to the component societies for study and comment so that a plan may be submitted to the House of Delegates at the Annual Meeting in August.

Worthy W. McKinney MD

W. W. McKinney, M. D., *President*

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EDITORIALS

WELCOME HOME

This month will see the closing of the term in office of Dr. Carl A. Hoffman as President of the American Medical Association. The closing of his term in office will not coincide with the closing of Doctor Hoffman's influence on the affairs of the American Medical Association or on the shaping of the style of medical practice in the United States. His imprint in these areas has resulted from the careful assimilation and application of his experiences in a life-time devoted to the care of patients and to the cause of all doctors conscientiously applying themselves to the most noble traditions of medical care.

Doctor Hoffman's curriculum vitae would do honor to any half-dozen men. In 1957, he was elected President of the West Virginia State Medical Association after having served as President of the Cabell County Medical Society. In 1958, he was elected Delegate to the American Medical Association and was regularly reelected thereafter.

In recognition of his qualities of leadership in the AMA House of Delegates, he was elected to the Board of Trustees of the American Medical Association in 1969. In 1970, he was elected Secretary-Treasurer of the American Medical Association. To those who knew him it was no surprise to see Doctor Hoffman win the office of President Elect in 1971.

Doctor Hoffman's term in medicine's highest office began in San Francisco in June, 1972. Later that summer he traveled throughout England, Sweden, Germany and Russia to make an objective study of the health-care systems in all of these countries. These studies have resulted in the opening of freer exchanges of information and knowledge between medical personnel in all of these countries.

Carl A. Hoffman, M. D.

Throughout the year he has maintained an incredibly active pace as he has symbolized in his speeches and in his very presence all the best there is to offer in Medicine. In his far-ranging travels he has been a proud and fearless advocate for organized medicine. Wherever he has been, he has generated immense respect for himself and for his profession.

The personal costs to Carl and his good wife, Lynn, will never be known. The gratitude we can offer will surely fall far short of what is deserved. In place of futile thanks, *The Journal* would simply like to express for all of us a heartfelt—WELCOME HOME TO WEST VIRGINIA, CARL AND LYNN.

FIGHTIN' AND FUSSIN'

No one wants to argue the fact that we have had a real problem in supplying family practitioners to the public, least of all, the authors of the two papers on that subject which we print elsewhere in this issue of *The Journal*. Both make it clear that this is not another problem unique to West Virginia or the Appalachian Region. As Doctor Sleeth points out in his paper, West Virginia has not had the problem as bad or for as long as many other places in the country.

Perhaps characteristically though, in seeking solutions for identified problems, we in West Virginia approach the task like the Hatfields seeking a solution to the McCoy problem. This is one way, at least, of accounting for all the clamor and shouting and shooting from the hip on the subject of medical education witnessed in Charleston during the regular session of the Legislature this year.

There is no question that the University has been slow and deliberate in its approach to establishing a Department of Family Practice and that this deliberateness has been galling and frustrating to members of the West Virginia Chapter of the American Academy of Family Physicians. In defense of the University's slow pace, Doctor Sleeth cites their very proper concern over the possibility of failure of the Family Practice program if entered into without adequate planning.

Perhaps the real issue is in the defining of *adequate planning*. What to an introspective academician is routine circumspection, to an action-oriented Family Practitioner is probably tedious ritual. The University as part of the State bureaucracy has reached a state of homeostasis with bureaucratic red tape to which the Family Practitioner reacts as if it were a foreign body. Both conditions are understandable and both require understanding.

Pressure has certainly been brought to bear on the University to stop its customary agonizing over minutiae and to get on with the establishment of the Department of Family Practice. *The Journal* encourages and supports an expeditious establishment of a Department of Family Practice at Morgantown. What needs to be suppressed is the expectation of immediate gratification of juvenile demands for instantaneous results.

What we don't need is an intercecine feud in West Virginia Medicine. There are plenty of other villains about for any doctor spoiling for a good fight.

THE CULTURE OF THE PHYSICIAN

It is fair to assume that physicians because of their long formal education, their rigorous scientific training, their extensive reading, and their interest in and contact with many types of people, may be regarded as cultured individuals. Indeed, they may be considered as one of society's most educated groups. Presumably the majority of physicians are interested in perusing good literature, at least as much as time allows.

About half a century ago articles and editorials appeared in widely read medical journals suggesting lists of books which the medical student might read during the long summer vacation. Incidentally, it is appreciated that many medical students no longer enjoy a long summer vacation; however, the thought of suggesting good books for them to read still seems to be a good one.

There are, of course, many worthwhile books to suggest, and each reader has his favorite list. The books mentioned in this essay are simply those which one editorial writer happens to like. They are all available in a good medical library, and while most of them are out of print, they really are not old books. It is to be remarked that the order in which they are listed bears no relation to their relative merit. The books which this author would like to suggest are these:

What Men Live By — William Osler
Aequanimitas — William Osler
The Life of Sir William Osler — Harvey Cushing
Harvey Cushing — John F. Fulton
The Life of Pasteur — Rene Vallery Radot
The Story of San Michele — Axel Munthe
Claude Bernard, Physiologist — J. Olmstedt
The Way of an Investigator — Walter B. Cannon
My Life and Medicine — Paul D. White

The Difficult Art of Giving — An Epic of Alan Gregg — Wilder Penfield

The writer of this essay is conscious of the fact that all the books mentioned may not appeal to all readers, but to try to please everyone is an impossible task. The writer's selection may be somewhat biased because he was acquainted with more than half the men whose work he mentions; some were his teachers and others his scientific friends. Actually, the list is merely suggestive and probably many outstanding books of interest to physicians may have been omitted. Be all that as it may, perhaps the list submitted will stimulate some students to prepare their own list. This would be a splendid idea.

Finally, as to the real motive for reading, one is reminded of a remark made by a successful novelist who is reputed to have said that the knowledge that a good book is awaiting one at the end of a long day makes that day happier.

HYPERTENSION SCREENING

The matter of hypertension has been discussed editorially in *The Journal* on numerous occasions. It is noteworthy that in the *Journal of the American Medical Association* (Medical News, February 26, 1973) attention is called to a Task Force, headed by Mitchell Perry, Jr., M. D., which will concern itself with a large-scale screening program for hypertension.

This is a most important matter for it is known that many individuals suffer from hypertension, many of whom complain of no symptoms. In point of fact, it has been estimated that from 10 to 23 per cent of Americans may have hypertension in some form; another estimate is that from 20,000,000 to 25,000,000 people are hypertensive. The results of the National Health Examination Survey, made about 10 years ago, showed that 3.7 per cent of white men and 12.5 per cent of black men, and 2.3 per cent of white women and 8.5 per cent of black women become hypertensives between the ages of 25 and 34 years. It is thought that the overall prevalence rates are about twice as high for blacks as for whites.

There is considerable divergence of opinion what constitutes hypertension. It is recognized, of course, that the level of diastolic pressure is much more important than the systolic; the diastolic level is the lowest pressure to which the vessels are constantly subjected, and this is important due to the time relations of the cardiac cycle. Some physicians are not especially concerned with the systolic pressure and believe that if the diastolic remains less than 100 mm. Hg. the patient needs no medication to control his pressure. This view is probably somewhat too liberal.

The entire matter of deciding what pressures, both diastolic and systolic are normal is an important but moot question. The American Heart Association has held that a systolic pressure of 140 mm. Hg. and a diastolic of 90 mm. Hg. should be the cut-off level. It was decided by the Task Force that the cut-off level for screening purposes would be 160 mm. Hg. systolic and 95 mm. Hg. diastolic for individuals who are 45 years or less. It is believed by some, but not by all, that as age advances blood pressure rises. The Task Force evidently believed that this should be taken into consideration in their screening evaluations and an additional 10 mm. Hg. is allowed for each level beyond the age of 45. This would permit a diastolic pressure of 105 mm. Hg.; some physicians would believe that this figure was too generous.

During the initial screening period the subject is expected to remain seated for approximately five minutes before the pressure is taken. The diastolic pressure to be measured at a point "equivalent to the fifth phase of the Korotoff's sounds." If the reading is not within bounds, the pressure is taken again at the end of 30 seconds.

The subjects will be divided into four groups after screening on the basis of three "casual pressure" readings. In essence the groups are to be divided as follows: The first group will include those with a systolic pressure of less than 140 mm. Hg. and a diastolic of less than 90 mm. Hg.; these would receive no further attention, except eventual reevaluation. The second group with systolic pressures greater than 160 mm. Hg. and diastolic greater than 95 mm. Hg. would get immediate referral. The third group would consist of persons with demonstrated "target organ damage" and these also would be referred. The fourth group would consist of individuals with no organ damage or historical evidence of hypertension, and would receive no further treatment, but a reminder that they should obtain another evaluation eventually.

Such a study as outlined above is a salutary approach to the problem of hypertension. Many people not only do not know that they are hypertensives, but also that anything can be done for them. It has been definitely shown that the control of hypertension greatly lessens the dangerous sequelae which may otherwise follow. Fortunately throughout the last two or three decades therapeutic agents have been developed which, if taken regularly, can maintain both systolic and diastolic pressures within reasonably safe levels.

GENERAL NEWS

Symposium on Family Practice Planned for Annual Meeting

Dr. James L. Grobe of Phoenix, Arizona, President of the American Academy of Family Physicians, has accepted an invitation to participate in a "Symposium on Family Practice" during the 106th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22-25.

Dr. A. Thomas McCoy of Charleston, Chairman of the Program Committee, announced that Doctor Grobe would join with several other prominent authorities in the field of family practice in presenting the program which will be held on Saturday morning, August 25.

James L. Grobe, M. D.

One of the other speakers will be Dr. Clark K. Sleeth, Acting Chairman of the Department of Family Practice at the West Virginia University School of Medicine.

Both Doctors Grobe and Sleeth spoke before the Annual Meeting of the West Virginia Chapter of the AAFP in Morgantown in April. The text of their remarks at that meeting may be found in the scientific section of this issue of *The Journal.*

James L. Grobe, M. D.

Dr. James L. Grobe, a native of Huntington, West Virginia, was graduated from Marshall University and attended the two-year West Virginia University School of Medicine. He received his M. D. degree in 1952 from the Medical College of Virginia and served an internship at Good Samaritan Hospital in Phoenix, Arizona.

He has been in a three-man family practice partnership at the Kalor Medical Clinic in Phoenix since 1953 and has been active in the Arizona Chapter of the AAFP and the Arizona Medical Association since that time. He is a Past President of both organizations.

He served as a member of the Congress of Delegates of the AAFP from 1961 to 1968, at which time he was elected to the Board of Trustees. He served as Chairman of the Board for two years prior to being named President Elect of the organization.

He is Immediate Past President of the Arizona Blue Shield, President of the Western Conference of Prepaid Medical Plans and a member of the Council on Mental Health of the American Medical Association.

In 1966, he was the recipient of an award from the Arizona Psychiatric Association for outstanding contributions to the field of psychiatry.

Speakers at First Two Sessions

Speakers for the first two general scientific sessions have been announced in previous issues of *The Journal.* The session on Thursday morning, August 23, will be devoted to a "Symposium on New Concepts in the Medical and Surgical Treatment of Coronary Artery Disease." The speakers and their subjects will be as follows:

C. Richard Conti, M. D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine. Subject: "Medical Therapy of Angina Pectoris."

James J. Morris, Jr., M. D., Associate Professor of Medicine, Duke University School of Medicine. Subject: "Angiographic and Hemodynamic Aspects of Coronary Artery Disease."

William H. Muller, Jr., M. D., Professor and Chairman of the Department of Surgery, University of Virginia School of Medicine. Subject: "Surgical Aspects of Coronary Artery Disease."

Friday Morning Program

The speakers for the general scientific session on Friday morning will be as follows:

Theodore M. King, M. D., Professor and Director of the Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine. Subject: "Abortifacients—Efficacy and Untoward Effects."

Alvin L. Watne, M. D., Professor of Surgery, West Virginia University School of Medicine. Subject: "Colon Polyposis and Colon Cancer."

John A. Kirkpatrick, Jr., M. D., Professor of Radiology and Pediatrics, Temple University School of Medicine. Subject: "Respiratory Obstruction in Differential Diagnosis and Diagnostic Techniques."

Dr. Russell B. Roth Honor Guest

It was announced previously that the honor guests will include Dr. Russell B. Roth of Erie, Pennsylvania, who will be installed as President of the

American Medical Association in New York City later this month. Doctor Roth will speak at the first session of the House of Delegates on Wednesday afternoon, August 22.

The Pre-Convention Meeting of the Council will be held on Wednesday morning and the final session of the House of Delegates on Saturday afternoon, August 25.

Room Reservations Pass 450 Mark

The number of room reservations at The Greenbrier for the 106th Annual Meeting in August has passed the 450 mark and it is anticipated that more than 700 persons including physicians, their wives and guests will be in attendance. All physicians who plan to attend the meeting are urged to make reservations as soon as possible. Early requests will assure physicians, their families and guests of room accommodations.

Additional information concerning the 106th Annual Meeting will be published in the July and August issues of *The Journal.*

Drs. Esposito and John Honored By Marshall University

Two Huntington physicians who have led efforts for location of a medical school at Marshall University have received Distinguished Service Awards from the MU Alumni Association.

The awards recently were presented to Drs. Albert C. Esposito and Winfield C. John during an alumni banquet in the Memorial Student Center. The two have been working for establishment of a medical school in Huntington in conjunction with the Veterans Administration under new federal programs.

Doctor Esposito, an opthalmologist, is a Past President of the State Medical Association (1964-65). Doctor John specializes in internal medicine and is a Past President of the Cabell County Medical Society..

B-Scan Ultrasound Conference In September At Baltimore

A conference on B-Scan Ultrasound will be held September 7 at Johns Hopkins Hospital, Baltimore, Maryland.

This conference is designed for radiologists, obstetricians and nuclear medicine specialists who have recently become interested in diagnostic ultrasound. It will be of particular value to doctors and technologists who are contemplating ultrasound scanning or have recently started B-scan ultrasound. Since B-scan ultrasound machines may, in addition, be used for echocardiography and echoencephalography, these topics will be briefly considered. Faculty will include G. Leopold, W. Cochrane and S. Uematso. Details can be obtained from R. C. Sanders, M. D., Department of Radiology, Johns Hopkins, Hospital, Baltimore, Maryland 21205.

Prominent Tax Lawyer To Speak At 106th Annual Meeting

One of the nation's foremost tax lawyers will be among the honor guests at the 106th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 22-25.

Mortimer M. Caplin, senior partner in the law firm of Caplin & Drysdale of Washington, D. C., will speak at an open meeting which will be held on Thursday afternoon, August 23. His remarks will involve matters of interest to practicing physicians and the Internal Revenue Service.

Mortimer M. Caplin, J.S.D.

Mr. Caplin was graduated from the University of Virginia and received his LL. B. degree in 1940 from the University of Virginia. He practiced law in New York City from 1941 to 1950—with time out for military service in the U. S. Navy. During the Normandy Invasion, he served as a Navy Beachmaster.

In 1950, Mr. Caplin returned to the University of Virginia to become a Professor of Law, specializing in tax and corporate law. He also continued in practice as a member of a Virginia law firm.

In 1960, following the election of President John F. Kennedy, Mr. Caplin served on the President's Tax Force on Taxation. In January 1961, President Kennedy appointed him U. S. Commissioner of Internal Revenue. He served in that post until July 1964 when he resigned to resume private law practice in Washington with his present firm.

On leaving government service, Mr. Caplin received the Alexander Hamilton Award, the highest award conferred by the Secretary of the Treasury for "outstanding and unusual leadership during service as U. S. Commissioner of Internal Revenue."

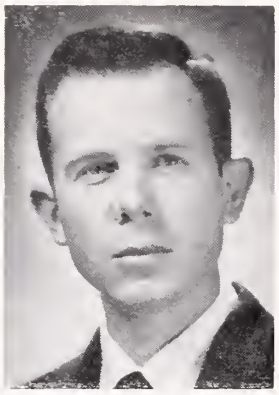
In 1953, Mr. Caplin received a J. S. D. degree from New York University and was awarded an LL. D. degree from St. Michael's College in 1964. He is a member of Phi Beta Kappa; Order of the Coif; the Virginia, Federal and American Bar Associations; and the American Law Institute.

He has written numerous articles on tax and corporate matters and has served as Visiting Professor at the Virginia Law School since 1964.

Mr. Caplin is a Trustee of George Washington University and the College of the Virgin Islands; President of the National Civil Service League; Vice President of the People to People Sports Committee and the Council on Foundations, Inc.

Alcoholism, Drug Abuse Seminar Scheduled June 17 At WVU

The Second Annual Physicians' Seminar on Alcoholism and Drug Abuse will be held on Sunday, June 17, at the Towers Conference Center, West Virginia University.



W. W. Spradlin, M. D.

Mildred M. Bateman, M. D.

The Seminar is being co-sponsored by the Division on Alcoholism and Drug Abuse of the West Virginia Department of Mental Health, and the Department of Behavioral Medicine and Psychiatry of the WVU School of Medicine.

The program will open at 9:30 A. M. with a welcome by Dr. Clark K. Sleeth, Acting Chairman of the Department of Family Practice, WVU Medical Center; and opening remarks by Dr. Mildred Mitchell Bateman, Director of the West Virginia Department of Health.

Other morning speakers and their topics will be:

"Experimental Studies of Alcohol Dependence in Animal Models"—Fred W. Ellis, Ph. D., M. D., Professor of Pharmacology at North Carolina University School of Medicine.

"Treatment of the Alcoholic in the Community Hospitals"—Charles L. Leonard, M. D., Director of the Detoxification Unit, Appalachian Mental Health Center, Elkins.

A Symposium on "Medical Aspects of Addiction" will be held in the afternoon. The speakers and their topics will include:

"Metabolic Aspects of Alcoholism"—Edmund B. Flink, M. D., Professor and Chairman of the Department of Medicine, WVU Medical Center.

"Effects of Alcoholism and Drugs on the Central Nervous System"—Ludwig Gutmann, M. D., Professor and Chairman of the Department of Neurology, WVU Medical Center.

"Pathology of Alcoholism and Drugs"—Milton R. Hales, M. D., Professor and Chairman, Department of Pathology, WVU Medical Center.

"Alcoholism as a Behavioral Phenomenon"—W. W. Spradlin, M. D., Professor and Chairman, Department of Behavioral Medicine and Psychiatry, WVU Medical Center.

Presiding for the Seminar will be Thomas Moore, Ph. D., Psychologist, Alcoholism and Drug Abuse Program, Valley Counseling Center, Inc., Morgantown.

Raymond E. Washington, Director of the Mental Health Department's Division on Alcoholism and Drug Abuse, said a $10 registration fee will be required. Overnight accommodations are available for a small additional fee at the Towers Conference Center. Continuing Education Credit will be given physicians attending the Seminar.

Participants are invited to remain for the Ninth Annual West Virginia School on Alcohol and Drug Abuse Studies, which follows the Seminar, June 17-22.

Renowned English Surgeon To Speak In Morgantown

Denis P. Burkitt, M. D., FRCSE, world-renowned English surgeon, will speak at a dinner meeting of the Monongalia County Medical Society on June 15 at 6:30 P.M. at the Lakeview Inn and Country Club in Morgantown.

Denis P. Burkitt, M. D., FRCSI

Dr. Alvin L. Watne, Professor of Surgery at the West Virginia University Medical Center, who made the announcement, said that Doctor Burkitt also will lecture at the WVU Medical Center on the same date at 4 P.M.

Doctor Burkitt, who served as a government surgeon with the British Colonial Service in Uganda from 1946 to 1964, is best known for first describing a form of cancer common in children in Africa, now named Burkitt's lymphoma.

Among numerous awards received by Doctor Burkitt is the Lasker Award, conferred in 1972, for his cancer work with the African children and continuing work in epidemiology of cancer throughout the world.

He has been a member of the British Medical Research Council External Scientific Staff since 1964. He is a Foundation Fellow of the East Africa Association of Surgeons and an Honorary Fellow, Sudan Association of Surgeons. Doctor Burkitt, who has made more than 100 contributions to scientific journals, was the Co-Editor of *Treatment of Burkitt's Lymphoma* (UICC Monograph 8), in 1967; and *Burkitt's Lymphoma*, in 1970.

His academic credentials include Dublin University, B. A., 1933; M. B., BCh., BAO, 1935; FRCSE, 1938; M. D., 1946; Surgeon, RAMC, 1941-46.

Doctor Watne said physicians are cordially invited to hear Doctor Burkitt. Those wishing to attend the dinner meeting are requested to contact Doctor Watne's office at the medical center for reservations. The telephone number is 293-3041.

State Physicians On Program Of AMA Convention

Dr. C. A. (Carl) Hoffman of Huntington will preside at the Annual Convention of the American Medical Association, June 23-28, in New York City. Doctor Hoffman, the first AMA President from West Virginia, will be concluding his term of office during the 122nd Annual Meeting (See Editorial on page 155). He will be succeeded by Dr. Russell B. Roth of Pennsylvania.

Frank J. Holroyd, M. D.

Richard E. Flood, M. D.

The West Virginia State Medical Association's two Delegates to the AMA House are Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, with Drs. George R. Callender, Jr., of Charleston, and Harry S. Weeks, Jr., of Wheeling, as Alternate Delegates.

The House of Delegates will hold its first meeting on Sunday, June 24, at 2 P.M. in the Imperial Ballroom of the Americana Hotel, the headquarters hotel.

The scientific program will begin on Sunday morning at the New York Coliseum. The theme will be "Confluence '73," marking a departure from former convention programs in that the stress will be shifted substantially toward continuing education for physicians. The scientific exhibits will be housed in the Coliseum.

Postgraduate courses will begin on Saturday, June 23, in the New York Hilton.

The Woman's Auxiliary to the AMA will meet at the Waldorf-Astoria Hotel.

State Physicians on Scientific Program

At least five additional West Virginia physicians will participate in convention activities. Serving on programs of Section Councils will be Drs. James T. Spencer of Charleston and W. Keith Morgan, West Virginia University Medical Center. Sponsoring a scientific exhibit will be Drs. G. Robert Nugent, Bruce Berry, and Harry Lowell from the WVU Medical Center.

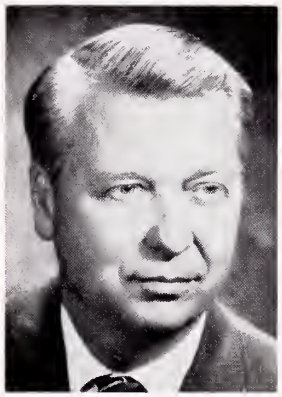
Doctor Spencer will be a speaker and panelist at a joint meeting of the Section on Otorhinolaryngology and the Section on Internal Medicine, entitled, "Symposium on the Ear in Systemic Disease." His topic will be "Hyperlipoproteinemia and the Inner Ear Disease."

Doctor Morgan will speak on "Functional Evaluation for Respiratory Status Among Occupational Risk Groups" at the "Symposium on Clinical Work-Up for Occupational Lung Disease." The Symposium will be held by the Section on Preventive Medicine, meeting jointly with the Section on Diseases of the Chest.

Drs. Nugent, Berry and Lowell will show an exhibit on "The Radiofrequency Treatment of Trigeminal Neuralgia" for the Section on Neurological Surgery.

During the week the AMA will present its highest honor — the Distinguished Service Award — to George H. Whipple, M. D., of Rochester, New York, the 1934 winner of the Nobel Prize in Medicine. The AMA's Layman's Citation for distinguished service will be presented to Bob Hope, who will be cited for his philanthropy and good-will efforts, particularly related to the Eisenhower Medical Center at Palm Springs and to numerous hospitals, research foundations and national health fund drives.

In addition to the main convention, a number of ancillary meetings will be held. These will include a special symposium on home health care, a session on medicine and religion, and a special conference on school health.



George R. Callender, Jr., M. D.

Harry S. Weeks, Jr., M. D.

On June 27 in the Hilton Hotel Grand Ballroom, a panel of experts will analyze for the attending doctors the potential role of acupuncture in the practice of medicine in this nation.

Full details of the AMA program were published in the April 16 issue of *The Journal of the American Medical Association.*

Dr. Zimmermann On ACS Faculty

Dr. Bernard Zimmermann, Professor and Chairman of Surgery at the WVU School of Medicine, served on the faculty of the first Spring Meeting of the American College of Surgeons held recently in New York City. Doctor Zimmermann, a faculty member for the Fluids and Electrolytes course, spoke at the session devoted to "Common Problems with Fluid and Electrolytes in Surgical Practice." His subject was "Hypertonic and Hypotonic States."

Waldorf-Astoria AMA Auxiliary Convention Site In New York

West Virginia's delegation to the Convention of the Woman's Auxiliary to the American Medical Association will be led by Mrs. Robert G. Janes of Fairmont, President of the Woman's Auxiliary to the State Medical Association.

Mrs. Robert G. Janes

The national meeting will be held June 24-28 in New York City at the Waldorf-Astoria Hotel.

Mrs. Robert F. Beckley, Auxiliary President, will preside at the formal opening on Monday, June 25, in the Grand Ballroom.

Harry Schwartz, Ph. D., author of the Book, *The Case for American Medicine*, will address the opening session. Dr. Carl A. Hoffman of Huntington, AMA President, will be the guest speaker at the annual luncheon honoring AMA officers, trustees, and wives on Monday.

The Tuesday luncheon, honoring Auxiliary national past-presidents and honorary members, will feature a talk on "Speech Can Change Your Life," by Dorothy Sarnoff, Director of Speech Dynamics, Inc., in New York.

State Public Health Association To Meet In Huntington

The 49th Annual Meeting of the West Virginia Public Health Association, Inc. will be held in Huntington June 6-8 at the Hotel Frederick.

Dr. Worthy W. McKinney of Beckley, President of the West Virginia State Medical Association, will deliver the Keynote Address at the first general session on Thursday Morning, June 7.

The slate of officers for 1973-74 will be Jane L. Johnson of Bluefield, Secretary, Planning and Administration, Southern West Virginia Regional Health Council, for President-Elect; Mary Ann Flaherty, R. N., Division of Maternal and Child Health, West Virginia Department of Health, Maternity and Infant Care Project, Memorial Hospital Division, Charleston, Vice-President; Doris Gray, Secretary, Environmental Health Services, West Virginia Department of Health, Bureau of Industrial Hygiene, South Charleston, Treasurer; and Eugene M. Ashworth (Past President), Charleston, Member-At-Large.

The current President is Louis S. Southworth, Associate Director, Division on Alcoholism and Drug Abuse, West Virginia Department of Mental Health. Mrs. Greta Pridemore of Charleston is Executive Secretary.

Medical Meetings

The following is a partial list of national, stat and district medical meetings scheduled in th coming months.

1973

June 6-8—W. Va. Pub. Health Assn., Hunt.
June 619—Am. Rheumatism Assn., L. A.
June 8-10—S. D. State Med. Assn., Rapid City.
June 10-14—Am. Proctologic Soc., Detroit.
June 12-15—Soc. of Nuclear Med., Miami Beach.
June 15—Dr. Denis Burkitt Lectures, Morgantown.
June 15-17—Pa. Allergy Assn., Hershey.
June 16-19—Maine Med. Assn., Kennebunkport.
June 17—Sem. On Alcohol & Drug Abuse, Morgantown.
June 17-21—Health Physics Soc., Miami Beach.
June 22-23—Am. Diabetes Assn., Chicago.
June 22-24—Soc. for Investigative Derma., New York City.
June 23-28—AMA, New York City.
June 24-27—Am. Assn. of Plastic Surgeons.
June 25-27—Health Records, St. Louis.
June 27-30—Idaho Med. Assn., Sun Valley.

July 16-19—Ruidoso (N.M.) Summer Clinic (N.M Chap., AAFP, Spon.).
July 28-Aug. 2—Natl. Med. & Dental Assn. of Am., French Lick, Ind.
July 30-Aug. 3—Am. Acad. of Clin. Toxicology, San Diego.

Aug. 19-20—Am. Acad. Med. Administrators, Chicago.
Aug. 20-23—Am. Health Congress, Chicago.

Aug. 22-25—106th Annual Meeting, W. Va. Stat Medical Assn., White Sulphur Springs.

Sept. 6-8—Am. Assn. Ob. & Gyn., Hot Springs, Va.
Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 17-18—AMA Cong. on Occupational Healtl Philadelphia.
Sept. 17-20—Ky. Medical, Louisville.
Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.
Sept. 18-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 20-23—Am. Soc. Internal Med., Dallas.
Sept. 27-29—Natl. Conf. Cancer of Colon & Rectun Bal Harbour, Fla.

Oct. 1-4—AAFP, Denver.
Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 7-11—Am. Soc. Anesth., San Francisco.
Oct. 15-19—ACS Clinical, Chicago.
Oct. 18-21—Amer. Acad. of Child Psych., Washing ton.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphu Springs.
Oct. 21-26—Am. Acad. Physical Med. & Rehab., Washington.
Oct. 26-28—Pot.-Shen. PG Institute, Martinsburg

Nov. 4-9—Am. Public Health Assn., San Francisc
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-13—Am. Heart Assn., Atlantic City.

Nov. 12-15—Sou. Medical Assn., San Antonio.

Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.

1974

Jan. 19-20—Mid-Winter Clinical Conf., Charleston

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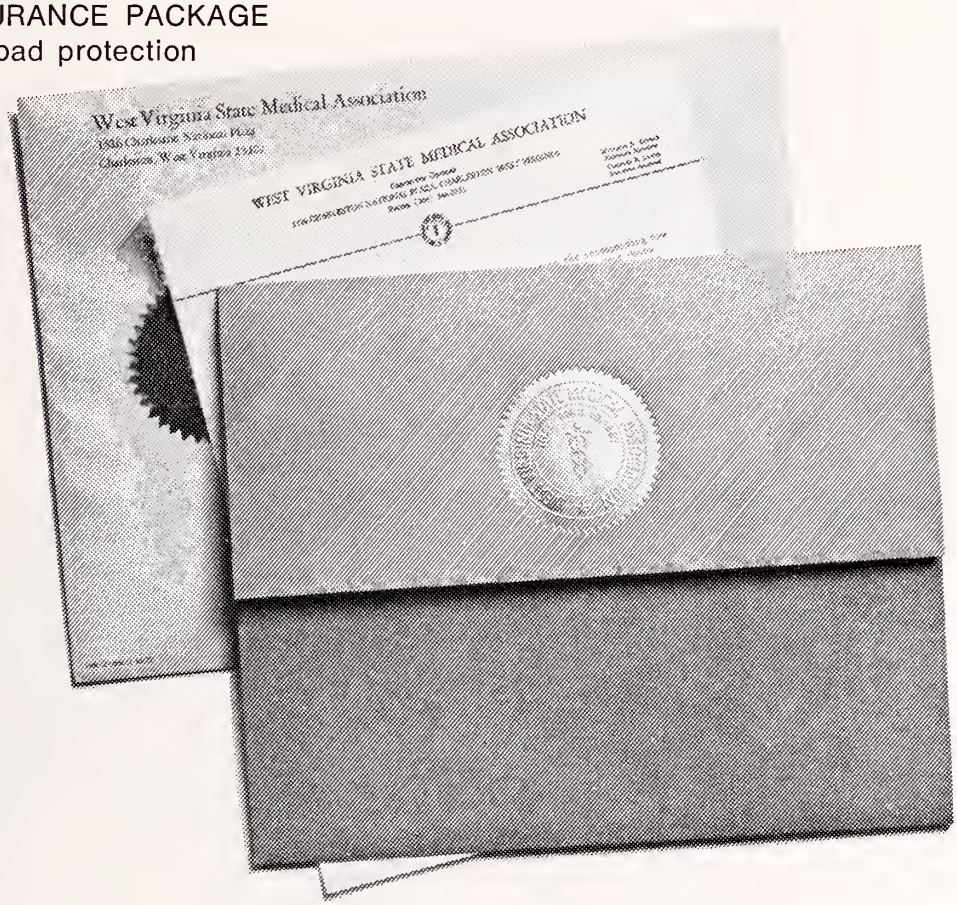

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WVU Medical Center
–News–

• Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

PRESIDENT James G. Harlow announced this spring that 115 West Virginia University faculty members have been promoted in rank or granted tenure. Among these advancements, effective July 1, are 26 within the School of Medicine.

Those in the medical school granted tenure or promoted to the ranks listed are:

Fouad H. Abdalla, Assistant Professor, Department of Radiology; Marianne Angert, Associate Professor, Division of Medical Technology; Sandy L. Burkhart, Assistant Professor, Division of Physical Therapy; Joan H. Burns, Assistant Professor (part-time), Division of Medical Technology; Donald C. Carter, Professor, Department of Behavioral Medicine and Psychiatry; Stuart T. Chen, Associate Professor, Department of Medicine; Morton H. Friedman, Associate Professor, Department of Anatomy; Robert J. Gardner, Associate Professor, Department of Surgery.

Albert H. Gelderman, Associate Professor, Department of Pathology; Francis L. Golden, Assistant Professor, Division of Physical Therapy; Ludwig Gutmann, Professor, Department of Physiology and Biophysics; Annette Helmick (Tanner), Assistant Professor, Division of Medical Technology; Marion K. Jacobs, Associate Professor, Department of Behavioral Medicine and Psychiatry; Billy E. Kirk, Associate Professor, Department of Microbiology; John M. Krall, Associate Professor, Division of Public Health and Preventive Medicine; Thomas W. McIntyre, Associate Professor, Department of Physiology and Biophysics.

Dane Moore, Professor, Division of Medical Technology; Robert S. Pore, granted tenure, Department of Microbiology (Assistant Professor); Eugene A. Quarrick, Professor, Department of Behavioral Medicine and Psychiatry; Wilbert W. Rankin, Associate Professor, Division of Otolaryngology; Anne W. Sharpe, Assistant Professor, Division of Medical Technology; Robert E. Stitzel, Professor, Department of Pharmacology; Paul H. Taylor, Assistant Professor, Division of Medical Technology; Knox VanDyke, Associate Professor, Department of Pharmacology; David P. Westfall, Associate Professor Department of Pharmacology; and Ida I. Yoder Assistant Professor, Division of Medical Technology

Making rounds in the University Hospital outpatient clinic before presenting the opening lecture for the WVU Medical Center's recent Cancer Teaching Day, Dr. Edmund Klein (center) discusses a case with (from left) Dr. Richard Hawkins, Resident in Dermatology; Dr. Ozdemir Bingul, Visiting Professor of Dermatology; Ann K. Clark, fourth-year medical student from Charleston; Dr. William A. Welton, Professor and Chairman of Dermatology, and Dr. Alvin L. Watne, Charleston Foundation Professor of Cancer Research. "Skin Cancer" was the topic of this year's sessions. Doctor Klein, pioneer in chemotherapy and immunotherapy, is Chief of Dermatology at Roswell Park Memorial Institute in Buffalo, New York.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE President of the American Medical Association filed a vigorous dissent to a federal Commission on Medical Malpractice report which blamed physicians and hospitals for much of the problem.

A central finding of the special commission was that injuries to patients, and not greedy avaricious contingency fee lawyers, are the reason for the increased number of malpractice claims. The report included about 100 findings and recommendations.

Views of Dr. Carl Hoffman

In his dissent, C. A. Hoffman, M. D., AMA President and one of the 21 members on the Commission, said that the panel had failed in its primary purpose to come up with a program "calculated to ameliorate" the nation's malpractice problems. Doctor Hoffman said:

"The report does not appear to be calculated to ameliorate such problems to any significant degree. Some of its recommendations, if implemented, would be likely to stimulate an increased frequency of claims. The increasing frequency and cost of claims has an unavoidable adverse effect on health care . . .

"The report fails entirely to identify the problems of medical malpractice claims as what they really are—a part of the much larger and more general problems of liability claims litigation. In the United States, people have always been quick to file lawsuits for any injury, real or imagined. The legal system encourages litigation. There is a definite trend in court decisions to make it continually easier for claimants to recover substantial damages, with less and less proof of fault.

"This trend is well established in all fields of activity including automobile liability, product liability, airline and rail liability, homeowners liability and all others. Malpractice liability is the most visible and harmful part of this trend, because it affects the vital area of health care.

Legal Doctrines Established

"A a part of this trend certain legal doctrines have been established which apply only in lawsuits against health care providers and which make it easier for claimants to recover damages with little proof of fault. These doctrines include: (a) the 'discovery' rule under the statute of limitations; (b) the application of the doctrine of res ipsa loquitur to injuries arising out of the performance of professional services; (c) the doctrine of 'informed consent' and (d) a rule allowing liability based on an alleged oral guarantee of good results. If this trend continues unchecked, the logical results will be that health care providers will be held liable for any unfortunate result arising from health care, even if there was no fault on the part of anyone and the result was entirely unavoidable.

"These legal doctrines are one of the most important causative factors for the problems of the increasing cost and frequency of malpractice claims. Instead of making a strong recommendation for appropriate and equitable remedial legislation, the report merely recommends referral of the legal doctrines problems, which it reluctantly admits exist, to some vaguely defined and presently nonexistent group which is supposed to develop recommendations for uniform rules of law, 'in the nature of a Restatement of the Law of Medical-Legal Principles.' This is inadequate as a remedy for this major problem.

"I, like other physicians, affirm that any patient who is injured in the course of his health care as a direct result of negligence on the part of any provider is entitled to just and reasonable compensation. Where an injury occurs despite the best of care, however, health care providers should not be unjustly burdened with the cost of compensation. If they are, this inevitably adds to the cost of health care.

Quality of Health Care Improving

"The report gives the false impression that the rapid increase in the frequency and cost of claims has arisen from a deterioration in the general quality of health care. The reality is the frightening paradox that the general quality of health care has been improving dramatically at the same time that the frequency and cost of claims have been skyrocketing.

"The report stresses the obvious fact that there would be no claims if there were no injuries. Where surgery or potent drugs are required, the risk of injury is unavoidable. Only a small percentage of the injuries, however, are caused by the negligence of anyone.

"The report does contain some constructive recommendations. These include: (a) development of injury prevention programs, (b) study of alternative compensation systems, and (c) data collection, if limited by careful cost justification."

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Obituaries

ALBERT EUGENE HARRINGTON, M. D.

Albert Eugene Harrington, M. D., of Elkins, who practiced his specialty of EENT for 40 years prior to retirement on January 1, died in Elkins on April 22 following a short illness.

A native of Ansonia, Connecticut, Doctor Harrington was graduated from Catholic University in Washington, D. C., and received his M. D. degree in 1932 from Georgetown University School of Medicine. He interned at Danbury and Greenwich Hospitals in Connecticut and then practiced for five years in Milford, Connecticut. He served residencies at the Yale University School of Medicine and Harvard Medical School.

During World War II he served for four years as a Major in the Medical Corps of the U. S. Army. Following the war he practiced in Lincoln, Nebraska, prior to moving to Elkins in 1963.

While in Nebraska, he served as President of the Adams County Medical Society and also served as President of the Tygart's Valley Medical Society in West Virginia. He was a member of the West Virginia State Medical Association and the American Medical Association.

Surviving are his widow; a daughter, Ann Elizabeth of Elkins; three sons, James R. Harrington of Omaha, Nebraska, Richard E. Harrington of New York City and William F. Harrington, II, of Newport News, Virginia; a brother, Dr. William F. Harrington of Stratford, Connecticut; and a sister, Mrs. Marquerite Buckley of North Haven, Connecticut.

Medical Center Listed Tops In Cancer Chemotherapy

West Virginia University Medical Center recently was listed as one of 46 "Top Hospitals in Cancer Chemotherapy" in the United States.

In the opinion of National Cancer Institute experts, a physician can confidently refer a cancer patient to any of the 46 hospitals, "where staff doctors, nurses and technicians have the training, expertise, and experience to use chemotherapy effectively."

The list was included in the first of a series of articles on "The Fight Against Cancer" that appeared last December in the periodical *Family Health.*

How did the Medical Center earn its place on the list?

When WVU Hospital opened its doors in 1960, chemotherapy was a new and undeveloped approach to the treatment of cancer. The 12 years since have seen chemotherapy emerge as one of the major approaches to cancer treatment, and West Virginia has contributed to these advances.

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County Societies

CABELL

The Cabell County Medical Society met on April 11 in Huntington. The guest speaker for the evening, Dr. Bosko Postic, gave an interesting talk on "Influenza and Pneumonia, 1973."

Dr. Thomas F. Scott, the President, appointed an Ad Hoc Committee to evaluate Professional Standards Review Organization (PSRO) legislation as it applies to the members of the Society. The committee members are Drs. Winfield C. John, Chairman; Harry K. Tweel, and Gary M. Tolley.

Plans were announced for a joint meeting with the Kanawha Medical Society on June 20 at the Sleepy Hollow Country Club at Hurricane, in Putnam County. — Charles H. McKown, Jr., M. D., Secretary.

* * * *

McDOWELL

The McDowell County Medical Society met on April 11 in Welch at Stevens Clinic Hospital.

Extensive discussion and review of the proposed amended By-Laws took place at this meeting. It was moved and approved that the proposed amended By-Laws be presented at the next meeting for passage.

It was called to the attention of members that the American Medical Association Convention will take place in New York City June 23 through June 28, and that the theme is "Confluence '73." — Emilio Delgado, M. D., Secretary.

* * * *

MERCER

Dr. Charles H. McKown, Jr., of Huntington, was guest speaker at the meeting of the Mercer County Medical Society on April 16 in Princeton at the Dinner Bell Restaurant.

Doctor McKown gave a very interesting talk on "Angiography in the Community Hospital." He illustrated many cases of tumors and cysts of the kidneys by means of lantern slides, and discussed aortic and subclavian and vascular anomalies of the cerebral circulation.

It was announced that Dr. Worthy W. McKinney, President of the State Medical Association, would visit the Society in May. Wives also have been invited to attend the May meeting.

Dr. A. J. Paine, President, discussed Federal plans to phase out certain hospitals or make them no longer eligible for Medicare benefits.—John J. Mahood, M. D., Secretary.

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J. N. Aceta, M. D.

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Clinical Laboratories:
Donna Burlenski
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Technologists:
Electrocardiography:
Betty Moguire, R. N.
Brendo Muklewicz, R. N.
Electroencephalogrophy:
Joann Green, R. N.
Juanita Stane, R. N.
Raentgenology:
Evelyn Forester, R. T.

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Lester L. Cline, Manager
Henry L. Castilow, Asst. Mgr.

MONONGALIA

Dr. Leslie F. McCoy, Director of Medical Services for the State Division of Vocational Rehabilitation, was guest speaker at the meeting of the Monongalia County Medical Society on April 3 in Morgantown at the Old Mill Club.

Doctor McCoy, who spoke on "Equal Disabilities Extended Syndrome," discussed the multitude of problems that a person faces following a suddenly disabling accident. He then told of ways in which his division can help these people and the ways in which physicians could work with the division.

The Society was informed that one of its members, Dr. Ralph Ryan, was named President-Elect of the American Association of Opthalmologists at its recent convention in Dallas. He also recently was elected to the Board of Directors of the Contact Lens Association of Opthalmologists.

The Society voted to recommend that the Mobile x-ray Program in Monongalia County be discontinued and that the supporting funds be diverted to venereal disease control, dental, or other more productive health programs. The recommendation was presented by the Public Health Committee. Dr. Isaiah A. Wiles, Chairman, noted that in recent years the number of active cases of tuberculosis found had dropped to almost zero.

The Society voted to contribute $25 to the Monongalia County 4-H Foundation, Inc. and $200 to Camp Kno Koma. — H. Summers Harrison, M. D., Secretary.

Physician-Patient Privilege Urged Kept In Federal Court Cases

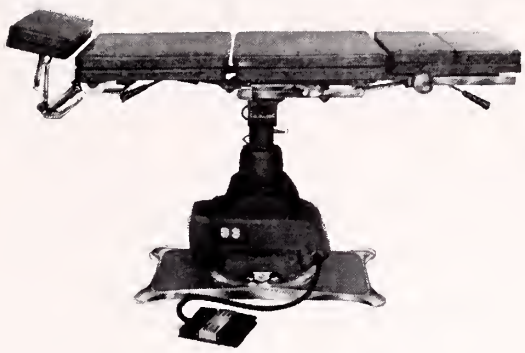
The American Medical Association recently warned of "possible adverse consequences" of abolishing the physician-patient privilege in federal court cases.

The AMA's "deep concern" was expressed in letters from Ernest B. Howard, M. D., AMA Executive Vice President, to the chairmen of the House and Senate Judiciary Committees which were considering such an abolition in the proposed new federal rules of evidence.

Doctor Howard reiterated the Association's position that "a qualified physician-patient relationship should be recognized." He said that the pertinent rule in the American Bar Association's Uniform Rules of Evidence would be preferable to the complete abolition of the privilege.

The House Committee was sent a copy of the AMA's statement on the matter presented to the Advisory Committee on Federal Rules of Evidence, Judicial Conference of the United States.

"We urge your committee to consider the effect of the abolition of the general physician-patient privilege noted in our statement and the confusion that may become prevalent if state and federal courts observe different rules when considering evidence based upon confidential communications made by a patient to his attending physician during the course of the physician-patient relationship," Doctor Howard said.



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AMA Labels Dr. Atkins' Diet Method 'Potentially Dangerous To Health'

The Council on Foods and Nutrition of the American Medical Association has labeled the dietary recommendations of the current best-seller book, *Dr. Atkins' Diet Revolution,* as unscientific and potentially dangerous to health.

The book recommends a sharply restricted intake of carbohydrates to lose weight. The author is Robert C. Atkins, M. D., of New York City.

"The 'diet revolution' is neither new nor revolutionary," the AMA Council declared in a formal statement analyzing the book's recommendations.

"It is a variant of the 'familiar' low carbohydrate diet that has been promulgated for years. The rationale advanced to justify the diet is, for the most part, without scientific merit."

Even more serious: "The Council is deeply concerned about any diet that advocates an 'unlimited' intake of saturated fats and cholesterol-rich foods (Another aspect of the Atkins diet)."

Individuals responding to such a diet with a rise in blood fats will have an increased risk of coronary artery disease and atherosclerosis (hardening of the arteries), particularly if the diet is maintained over a prolonged period, the Council said.

The book states that the diet promotes production of a "fat mobilizing hormone" (FMH) . . . "and the production of FMH is the whole purpose of this diet — and the reason it works when all other diets fail." According to Doctor Atkins, "FMH releases energy into your bloodstream by causing the stored fat to convert to carbohydrate."

No such hormone as a "fat mobilizing hormone," has been established in man, said the AMA Council. In addition, no appreciable conversion of fat to carbohydrate occurs in the human body.

Carbohydrates are organic chemical substances containing carbon, hydrogen and oxygen. They are important sources of energy for the body. Sugar and starches, such as potatoes, rice and wheat flour, are important sources in the everyday diet.

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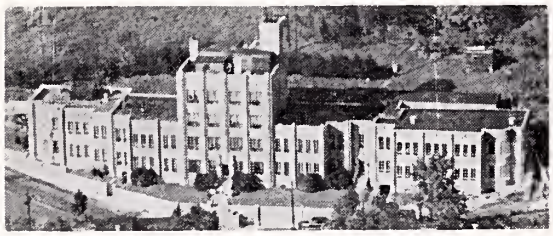

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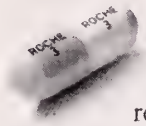

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Precautions: In the elderly and debilita and in children over six, limit to smallest effe tive dosage (initially 10 mg or less per day) t preclude ataxia or oversedation, increasing gr ally as needed and tolerated. Not recommend in children under six. Though generally not r ommended, if combination therapy with oth psychotropics seems indicated, carefully consi individual pharmacologic effects, particularly use of potentiating drugs such as MAO inhib and phenothiazines. Observe usual precautio presence of impaired renal or hepatic functio Paradoxical reactions (*e.g.*, excitement, stimul and acute rage) have been reported in psychia patients and hyperactive aggressive children. Employ usual precautions in treatment of an states with evidence of impending depression suicidal tendencies may be present and protec measures necessary. Variable effects on blood coagulation have been reported very rarely i patients receiving the drug and oral anticoagu lants; causal relationship has not been establis clinically.

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JULY 1973

What should a medication for sleep be expected to provide?

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psycholo dependence have not been reported recommended doses, use caution in ministering to addiction-prone indiv or those who might increase dosage

Precautions: In elderly and debilitat initial dosage should be limited to 15 to preclude oversedation, dizziness or ataxia. If combined with other dru having hypnotic or CNS-depressant effects, consider potential additive e Employ usual precautions in patien who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

Sleep with consistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane; no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. Dalmane is generally well tolerated and morning "hang-over" is relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in elderly and debilitated patients. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

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depression or suicidal tendencies.
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se Reactions: Dizziness, drowsi-
ightheadedness, staggering, ataxia
ling have occurred, particularly
rly or debilitated patients. Severe
on, lethargy, disorientation and
probably indicative of drug intoler-
r overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
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Maker of Medicine

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"Too many doctors are indif ent to the economic consequence their decisions." So stated a recer issue of *Medical News Report* (De cember 4, 1972), an independent weekly newsletter published by fo AMA Chief Executive F. J. L. Blasi game, M.D.

Doctor, are you indifferent...?

In discussing an anticipated crease in Blue Shield rates, Dr. Bl ingame's newsletter had this to sa

"In general, it can be said, M have given the impression they ar not particularly concerned with th increase in cost of health care to t patients...

"True, an MD's training is pr marily scientific, but in the real w of practice, all of his scientific de sions have a price tag, or an econ impact. The economics of health beckon the practitioner's attentio Concern for economics of medici

When the pharmacist recom mends that a drug product other t the one ordered be dispensed, the prescriber invariably permits the change when he feels the best int ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is ne sary for the prescriber to know th the change is being contemplatec and to be in a position to consent demur. Without that opportunity, unilateral decision of the pharma made in the absence of clinical kr edge of the patient, could expose to needless risks, and in addition, jeopardize the relationship betwe the professions of Pharmacy and Medicine. In my view, there is not in the pro-substitution argument t offsets these risks.

The Issue of Drug Knowledge

Substitution advocates clair that the primary justification for changing the rules is the desire to better utilize pharmacists' knowle about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some deg puts him at a disadvantage. Most often, a practicing physician will r expert knowledge of no more than 5

Advertisement

d be an obligation of medical ice...

"Medical societies ought to con- continuing campaigns to point e substantial savings that could alized thru deductible insurance rotection for catastrophic ill- At the very least, they should, in atients' interest, question the s of any insurance organization aises health care costs by forc- olicyholders to buy insurance may not need or want and prob- von't ever use.

"Too many doctors are indiffer- the economic consequences of decisions. Too many, for ex- e, habitually hospitalize patients e convenience of the MD. It's ense to deny such habits exist...

"Doctors, thru their medical so- es, have unhesitatingly appealed eir patients for support in the against government interference the private practice of medicine. the public in the past has re- ded. It's time the American Med- Association and state and local cal societies paid off the debt by sive action to hold down the cost edical care."

of Drugs

Insurance rates and hospital ges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

) drugs that he selects to treat the rity of conditions encountered in ractice. Moreover, the physi- 's choice of a specific brand is d on his knowledge of the pa- 's medical history and current dition, and his experiences with particular manufacturer's luct.

Some substitution proponents argued that the dispensing of a cription is a simple two-party saction between the pharmacist the patient, and that a substitut- pharmacist may avoid even a nical breach of contract by simply fying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted out physician approval and who ertook a legal defense that seeks ake the patient responsible for pharmacist's actions.

uced Prescription Prices?

Substitution advocates are gesting to the consumer, and par- larly the consumer activist, that uced prescription prices could w legalization of substitution. have seen absolutely no evidence stify this claim. To the contrary, erience in Alberta, Canada, where stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

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1526 Charleston National Plaza
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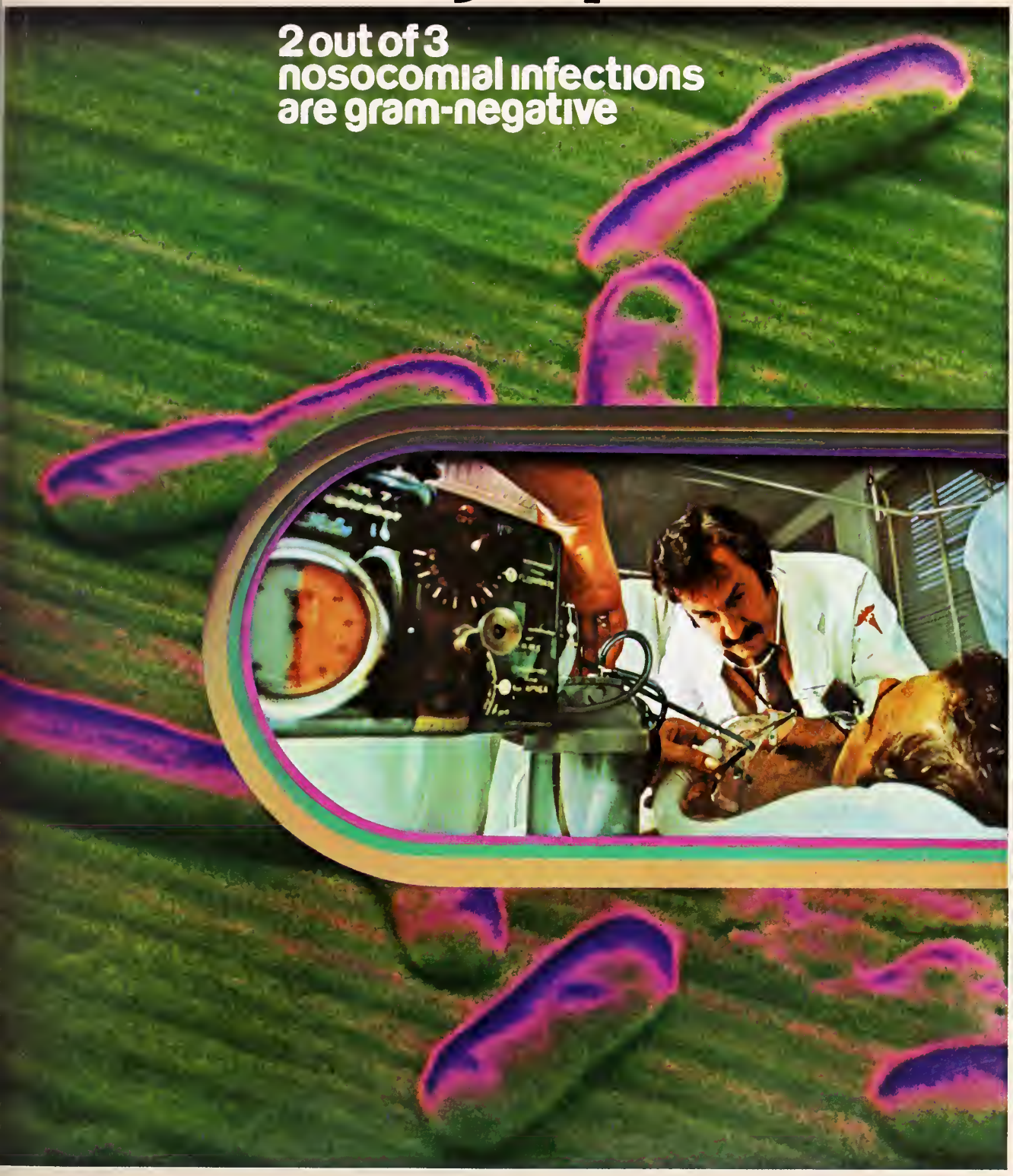
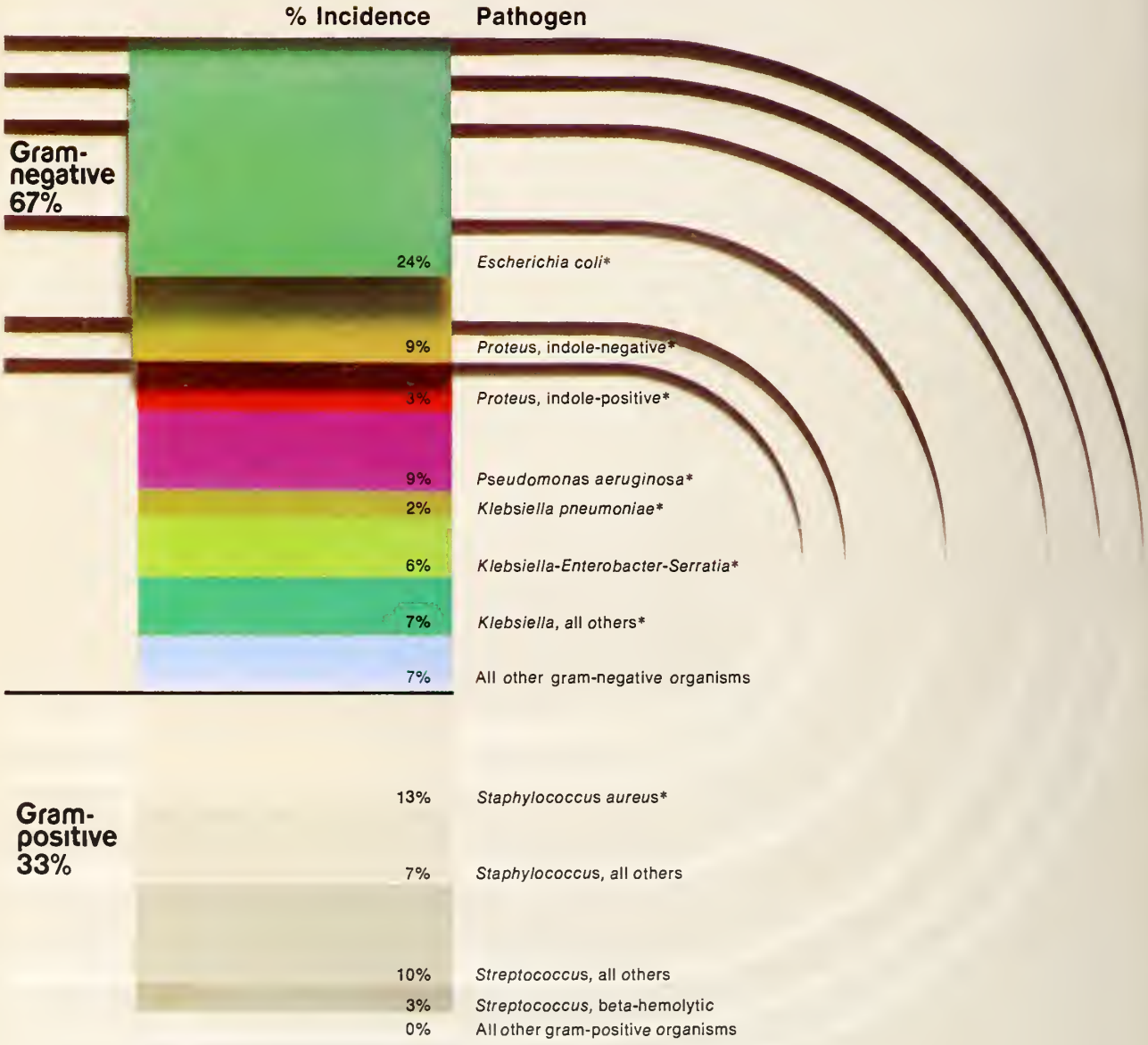
Schering

On all in-patient services... a major problem



Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.

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Schering

A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella, *Enterobacter*, *Serratia* } species

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

In serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)*
*Due to susceptible organisms

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Schering

On all in-patient services...
in hospital-acquired gram-negative infections*

Garamycin®
gentamicin sulfate injectable
I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

Also available:
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

GARAMYCIN® Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin
For Parenteral Administration

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, Proteus species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

PATIENTS WITH NORMAL RENAL FUNCTION*

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

*Due to susceptible organisms

SLR-301

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol SODIUM
(SODIUM BUTABARBITAL)

Contraindications: Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

T_4 IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)[1]; (2) since SYNTHROID contains only T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...*to thyroid replacement therapy*

ENTS CAN BE
ESSFULLY
TAINED ON A
G CONTAINING
ROXINE ALONE.

ne (T_4) is, as you know,
or circulating hormone
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nation," was demonstrated
erman, Ingbar, and Sterling[2].
convert to T_3, though the
quantities are still being

conversion has been
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s. Their thyroid status is
zed on SYNTHROID alone,
presence of T_3 in these
s has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

ynthroid®
dium levothyroxine)

FACTS ARE
AR AND HERE
UR OFFER.

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tic thyroid drugs are an
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Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

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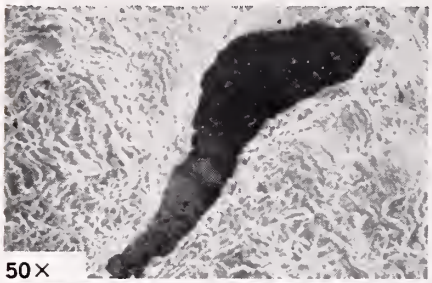
Progress i

Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50×), a fibrin strand (300×), and a whitish exudate composed of polymorphonuclear leukocytes (1000× and 3000×). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



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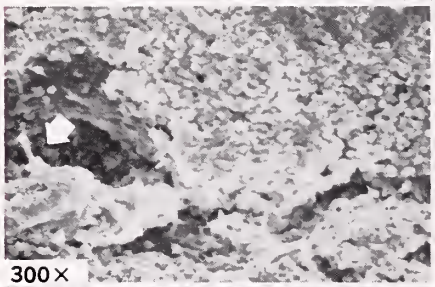

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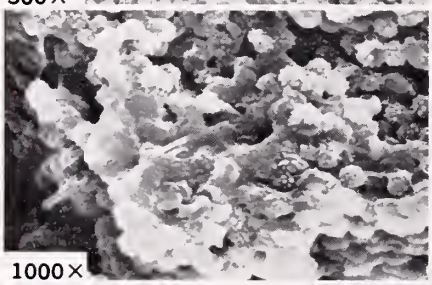

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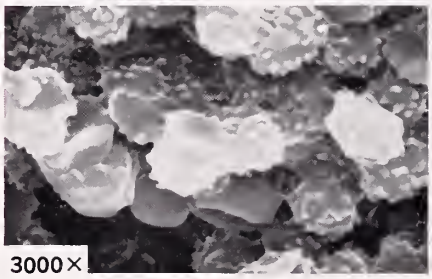

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A note on the photography: These photographs were made by ning electron microscope, which, transmission electron microscope, on the basic principle of exposure to a beam of electrons in a vacuun the SEM, electrons bombard the s of tissue which has been given a fi ing of gold. The electrons reflect o tissue onto a television screen, an resulting photograph shows a thre sional effect. The tissue sections r be ultrathin, so there is a minimur handling and distortion.

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References: **1.** Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther., 12*:525, 1971. **2.** Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc., 44*:318, 1969. **3.** Hibbard, L. T., in Bulger, M. J., *et al.: Patient Care, 1*:(3) 47, 1967. **4.** Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol., 102*:249, 1969. **5.** House, T. E., *et al.: Obstet. Gynecol., 34*:670, 1969. **6.** Lampe, W. T.: *J. Am. Geriatr. Soc., 16*:798, 1968. **7.** Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res., 13*:286, 1971. **8.** Normand, I. C. S.: *Practitioner, 204*:91, 1970. **9.** Pryles, C. V.: *Med. Clin. North Am., 54*:1077, 1970. **10.** Seneca, H.; Peer, P., and Warren, B.: *J. Urol., 99*:337, 1968. **11.** Trafton, H. M., and Lind, H. E.: *J. Urol., 101*:392, 1969. **12.** Cohen, M.: *Pediatrics, 50*:271, 1972.

Before prescribing, please consult complete product information, a summary of which follows:

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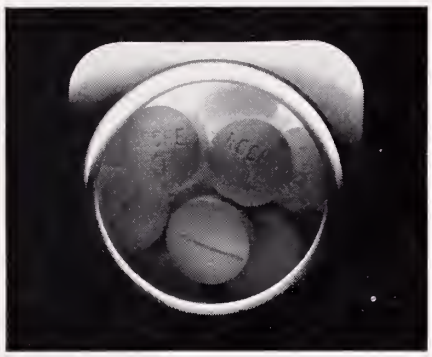
ry levels As a urinary anti- Gantrisin (sulfisoxazole) r patients important ad- Therapeutic urinary and ncentrations are usually from 2 to 3 hours and can ined on the recommended day dosage schedule that's t for almost all patients.

good tolerance Gantrisin latively few undesirable , and serious toxic reac- are. Minor reactions are ively infrequent, but may ausea, headache and vomit- e, Gantrisin may usually even for extended periods ating chronic or recurrent ucted cystitis, pyelitis or hritis due to *E. coli* and ceptible organisms. (See t Note in summary of prod-



uct information.) Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

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total therapy: 14 days Recent evidence in the medical literature suggests that therapy in acute nonobstructed urinary tract infections should be continued for 10 to 14 days even if patients become asymptomatic in 2 or 3 days, as they often do.[1-11] However, one investigator, evaluating a 5-year study of sulfisoxazole used to treat urinary tract infection in 368 girls, found no advantage in continuing therapy more than two weeks *for a first infection.*[12]

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, frequently dose-related, may ucose-6-phosphate dehydro- ficient patients. Maintain fluid intake to prevent crystal- tone formation.

eactions: *Blood dyscrasias:* ytosis, aplastic anemia, throm- ia, leukopenia, hemolytic ane- ra, hypoprothrombinemia and globinemia; *Allergic reactions:* multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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The West Virginia Medical Journal

Vol. 69, No. 7 July, 1973

Uterine Cytology:

Changes in Concept of Diagnostic Interpretation (1952-1973)

Peter P. Ladewig, M. D.

The Author

- **Peter P. Ladewig, M. D., Charleston School of Cytotechnology, Inc., and the Cytology Section, Department of Pathology, Charleston Area Medical Center (General Division), Charleston, West Virginia.**

In March of 1952, Diagnostic Cytology in the Kanawha Valley started with the first screening project for cervical cancer at Laird Memorial Hospital in Montgomery, West Virginia, now Montgomery General Hospital. In 21 years Diagnostic Cytology has changed concepts, and it seems worthwhile to look back and remember.

Twenty-one years ago, in 1952, it was only a few years since Papanicolaou and Traut (1943) had published their "Atlas" of the cell picture of uterine malignancies (Papanicolaou, G. N. and Traut, H. F.: Diagnosis of Uterine Cancer by the Vaginal Smear. New York, Commonwealth Fund, 1943). The storm of adversities which had hit this work was still in full swing, and merely a handful of physicians, practitioners as well as pathologists, believed then that it was worth a trial to obtain Papanicolaou smears and judge the method rather from personal experience than from the level of the dogma, that single cells and their criteria of morphology could not be evaluated for the establishment of the diagnosis of malignancy; malignancy was believed to find its expression only by combination of cell criteria and patterns of tissue architecture, such as given in the classical approach of histopathology.

At the same time, although anticipated by clinicians all over the world for at least a quarter of a century before, the concept of a carcinoma-in-situ as the almost obligatory forerunner of invasive cancer was viewed by the majority of physicians at best as utopic thinking and at worst as a fake.

Today, in 1973, Papanicolaou stands as an undisputed hero in the Hall of Fame of Modern Medicine. Cytology has come of age! The world over, physicians strive to detect the very first signs of unrest in the epithelial linings of the uterine cervix in order to detect the carcinoma-in-situ which is almost undisputedly seen as the first irreversible stage in the gamut of cellular changes leading eventually to the invasive form of malignancy, the cancer.

It is fully realized today that once a carcinoma-in-situ of the cervix has been spotted by cytology and confirmed by biopsy, the cure rate of this condition by appropriate surgical methods is practically 100 per cent, while the cure rate of subsequent stages of malignancy, even in their early phases, remains well below this optimal and ideal goal.

The 21 years of Diagnostic Cytology coincide, therefore, with the time lapse in the history of Medicine where we had the first glimpse of a perfect cancer cure.

Importance of Early Diagnosis

It is, of course, well understood that this pathway applies at the present time only to the cancer of one site of the human body and one approach to the overall problem, namely, that of early diagnosis. Nonetheless, this one approach is also at the present time the only way to a possible eradication of cervical cancer which,

until a few years ago, was the killer of between 10,000 to 15,000 women yearly in the United States. Nothing could speak with a more persuasive voice in favor of the pursuit of this one-way combat of cervical cancer than the statistics of the last few years all over the world, showing for the first time a true, physician-made decline in the death rate from a specific cancer in those parts of the world where genital cytology is practiced on a systematic and routine basis. Fewer women, indeed, die now from cervical cancer than did ever before, and, we may say with gratitude and humility that this applies to West Virginia as well as to other areas of our world.

Table 1

DIAGNOSTIC TERMS IN GENITAL CYTOLOGY

(Correlated to Outdated Five "Classes")

"OLD" CLASS	ESSAY TYPE DIAGNOSIS
None or "0"	(a) "Technically unsatisfactory" (too thick, too thin, air dried, etc.). (b) "No endocervical cells;" in this material no tumor cells seen; however, possibly not representative. (c) (Hormonal evaluation, such as) maturation index . . . etc.
I.	(a) No atypicalities seen. (b) Compatible with effect of (stated hormone) therapy.
II.	(a) Benign, reactive metaplasia.* (b) Benign, reactive metaplasia and slight dysplasia.** (c) Same as (a) (b); consistent with cervicitis. (d) Same as (a) (b), consistent with trichomoniasis. (e) Benign, slightly dysplastic keratosis°) with any of the additional comments as in (c) and (d). (f) Reserve cell hyperplasia+) – with any of above. (g) Cellular picture indicates (unexplained) hormonal response; is patient on hormonal medication? Digitalis?++) _____. (h) Add to any of above, (a) to (g) if desired. Repeat in _____ weeks/months. (i) Add to (c) or (d) if desired "repeat after treatment."
III.	(a) "Marked atypicalities, short of definite signs of malignancy _____;" plus (1) or (2); (see below). (b) "Severe dysplasia _____;" plus (1) or (2); (see below). (1) "Obtain biopsy to rule out malignancy." (2) "Repeat smear immediately;" or "repeat smear in _____ weeks, after treatment of infection or _____ after treatment with course of estrogen, etc." (c) Endometrial cells present in postmenopausal patient (!): The possibility of an endometrial adenocarcinoma has to be ruled out (Plus (1) or (2); or "obtain smear from uterine aspiration;" or "obtain fractionated curettement, etc."
IV.	(a) (Highly) suspicious of carcinoma-in-situ; rule out atypical reserve cell hyperplasia (recommend type of diagnostic procedure such as cold cone biopsy, multiple biopsies, fractionated biopsies, etc. (b) (Highly) suspicious of adenocarcinoma (endocervix? endometrium?). Recommend type of diagnostic procedure; see under (a). (c) (Highly) suspicious of squamous cell carcinoma ("cancer"); rule out dysplastic keratosis. Recommend type of diagnostic procedure; see under (a). (d) Many mitotic cell divisions in cells which could be either histiocytes or atypical columnar cells. Recommend diagnostic procedure; see under (a).
V.	(a) Consistent with carcinoma-in-situ; (recommend diagnostic procedure). (b) Consistent with "cancer" (squamous cell carcinoma); recommend diagnostic procedure. (c) Consistent with adenocarcinoma, primary of _____ (endocervix; endometrium) (Recommend diagnostic procedure. (d) Consistent with metastatic _____ carcinoma; recommend diagnostic procedure.

(*) **"Metaplasia": A condition of adaptation of a mature, low resistance tissue or cell type to another mature tissue or cell type of higher resistance, f.e., metaplasia of single-layered columnar cell (or glandular) epithelium to multi-layered squamous cell epithelium.**

(**) **"Dysplasia": An aberration of shape of cells, usually going along with enlargement of cytoplasm and nuclei, which is thought to be caused by varying degrees of biochemical malfunction. It may be "slight" and, therefore, less significant ("dangerous") or "severe" and, therefore, highly significant ("highly dangerous") from the point of transformation to tumor cell. Columnar (glandular) and squamous cells may be affected by "Dysplasia."**

(°) **"Keratosis": Indicates cornification of epithelium which usually is not encountered in the genital tract and represents as such a special form of "metaplasia."**

(+) **"Reserve Cells" occur as the youngest forerunners of all epithelial cells in the genital tract in restricted numbers; their increase in number (= "hyperplasia") may spell out unusual growth activity of the epithelium. It is almost always encountered in the epithelial layers of pregnant women and those on birth control medication.**

(++) **Some drugs such as, f.e., digitalis and tetracyclin have a stimulating effect on epithelium similar to estrogenic hormones.**

Note: All cytological examinations become clinically meaningful only if referral slips contain such basic clinical information as patient's age, LMP, history of discharge or bleeding, pregnancy history, history of previously diagnosed or treated malignancies; dates of previous abnormal cytological tests and history of hormonal or other pertinent medication.

In cases of need, on either side, additional important information between clinician and cytopathologist may conveniently be exchanged by brief telephone conversations.

During these years of evolution of cytology, the tactical approach to the interpretation has changed considerably. When Papanicolaou presented his method to the medical world, he had just barely seen the outlines of criteria which could or should be applied to the evaluation of Papanicolaou smears. There were those cell pictures which were unequivocally "normal," and those which were unequivocally malignant. He thought it best to subdivide the gamut between these two extremes into five categories which he conceived of as "Classes."

Obviously, with the very limited experience of that time, varied criteria were applied by many different groups of pathologists and physicians and, therefore, the borderlines between the five classes remained variable and vague; this held especially true for those "gray areas" where it meant most to separate the purely temporary and reactive cell abnormalities from those indicating irreversible, self-sustained neoplastic changes: the "inconclusives" and the "conceivably suspicious" were herded aimlessly into a "Class III."

Although by no means definite from the point of view of an ultimate goal of exactness, cytology has since learned to interpret the morphology of the isolated cell by various criteria, especially those of nuclear and nucleolar configuration; sizes and size-relations, distribution of chromatin, etc. These criteria approach in their diagnostic validity closely those long before established for the appraisal of biopsies.

'A Powerful Ally to Histopathology'

This does not mean, and should certainly not be interpreted as saying that cytology has replaced or is in the process of replacing histopathology in the evaluation of cell or tissue changes. It is fully meant as stating that classical histology has received a powerful ally and associate in the armamentarium to combat malignancies.

It can, furthermore, be said with emphasis that the interpretation of cytological cell pictures in the hands of competent cytologists goes today much further than giving hints of possible existence of malignancies.

The reading of a Papanicolaou smear in 1973 precludes the vagueness of the original "number game" which in its time served as an enormously valuable weapon. Papanicolaou's "Classes" are now outdated! They have been replaced by more precise insights into the cellular mechanism of "the making of a cancer," and even into other diagnostic problems such as whether or not given cellular changes represent in-situ carcinoma or an invasive carcinoma; squamous cell carcinoma or adenocarcinoma; or, in other settings, whether and which cytological pictures may be indicative of hormonal disturbances.

These are the considerations which have made it necessary to switch the diagnostic evaluation of cytological material from the original five-class system of Papanicolaou (or any similar "number game") to a more versatile, more expressive and, therefore, clinically more relevant type of diagnostic reporting which requires the use of essay type language similar to that commonly used and accepted in histopathology.

Essay-Type Diagnostic Terms

Our Cytology Section has used and developed over the last few years a sequence of essay-type diagnostic terms in genital cytology (similar in many respects to that worked out by other cytologists throughout the world) which we believe do more justice to the advances in the interpretation of cytological findings and their clinical correlation than "Classes" by numbers ever could. Groups of terms which we use correlate, of course, to some extent to the five classes of Papanicolaou's which are once more briefly characterized as follows:*

Class I —No cellular atypicalities.
Class II —Benign cellular atypicalities.
Class III—Cytologically or biologically doubtful or inconclusive.
Class IV—Suspicious of malignancy.
Class V —Consistent with malignancy.

This, at least, is the interpretation which we had given to the classes used prior to the introduction of essay terms. It is obvious that the "Class III" contained under its heading a hodgepodge of "I don't know" conditions which were considered by everybody as a thicket of danger. With newly gained knowledge this area of doubt and uncertainty has started to dissolve itself into more definable entities, such as, innocuous and less innocuous (atypical) reserve cell hyperplasias or the gamut of "dysplasias" which in every case deserve a more clinically minded interpretation.

It would lie beyond the purpose of this presentation to go into the more technical or theoretical details of diagnostic reporting of genital cytological material, which is presented here as

*No "slot" existed within Papanicolaou's five diagnostic "classes" for the relatively large number of cases which defy valid interpretation because of technical shortcomings.

We marked this material for some time as "Class O," to the discontent of many practicing physicians.

It is hoped that the new essay type of comments will open clearer lines of communication between cytologist and practitioner to the benefit of their patients.

it is used by our Cytology Section at this time, and which we believe has proven to be advantageous to clinicians and their patients alike.

New System of Essay Diagnostic Terms

In Table 1 we have arranged diagnostic terms which we use against the background of the "old" Papanicolaou classes in order to make correlation with and transition to the newer system easier and more readily accessible for clinical use. It is obvious that different cytologists, pathologists and clinicians may use and have used different types of classifications and correlations. It is exactly for this reason that we believe the new system of essay diagnostic terms will make the meaning of cytology more precise and less equivocal. The great activity which is going on in the field of cytology, especially in connection with basic research on problems of cell regeneration and transformation, will make changes in the field of applied diagnostic cytology necessary at frequent intervals and hopefully bring an increasingly clearer picture to the team of physicians entrusted with the well-being of the patient.

A warning may be mandatory at this stage of the game where cytology has come of age: The interpretation and use of cytology in the framework of medicine has outgrown guesswork and the meddling of incompletely or haphazardly trained workers in the field. Cytological work demands and requires expert schooling as well as years of actual experience; it should be handled exclusively in institutions which not only have access to immediate competent histopathological correlations but also direct access to dialogue between clinician and cytopathologist, which is actually the key feature in the new development of clinical cytology.

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To all physicians in training and especially West Virginia residents. West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal*. *The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual immediate attention.

Medullary Sponge Kidney

(Review of the Literature and Presentation of Four Cases)

Stephen Allen Stuppler, M. D.; Stanley J. Kandzari, M. D.; and D. Franklin Milam, M. D.

Introduction

The active practicing urologist spends a great deal of time interpreting intravenous pyelograms and treating patients with renal calculus disease. In the course of these endeavors, medullary sponge kidney disease is not uncommonly encountered. With this in mind, the authors reviewed the pertinent literature on the subject and report four representative cases.

The Authors

- **Stephen Allen Stuppler, M. D.; Stanley J. Kandzari, M. D.; and D. Franklin Milam, M. D., Department of Surgery and Division of Urology, West Virginia University Medical Center, Morgantown.**

Medullary sponge kidney is a distinct disease process with a well documented history in the Italian literature. Lenarduzzi originally described the radiological aspect of the problem. In 1938, he described a pyelogram demonstrating punctate nephrocalcinosis restricted to the renal pyramids. The contrast material was seemingly held within dilated collecting tubules which also contained calcium density concretions.[1] Cacci and Ricci formally named this observed phenomenon "Rene a Spugna" or sponge kidney.[2] Ekstrom et al, in 1950, examined 44 cases of medullary sponge kidney from all medical aspects and reviewed the Italian literature on the subject.[3]

Vermooten, in 1951, described a case of "congenital cystic dilatation of the renal collecting tubules." His report introduced this "new disease entity" to the English literature. He also proposed a pathophysiologic etiology for these findings.[4] In 1960, Abeshouse and Abeshouse,[5] in a scholarly review of the world literature on the subject, collected 131 cases and added five of their own. During the 1960's, clinicians became more aware of the disease process and the British and American literature yielded more cases. As recently as February 1972, Spence and Singleton[6] discussed sponge kidney in the spectrum of cystic renal diseases. They noted that over 250 cases had been reported.

Description

Medullary sponge kidney is a condition in which all or most of the collecting tubules within the renal pyramids are ectatic. Multiple small cysts, one to three millimeters in size, also are found in the renal medulla. The process most often is bilateral. Calculi in the renal pyramids were seen in 88 of 131 cases in the Abeshouse[5] review. The calculi were noted by Ekstrom to be highly radiopaque.[3] Infection was present in 44 of 131 cases.[5] The small cysts present have been given descriptive terms according to intrapyramidal arrangement: (1) fan-shaped, (2) bunch of flowers, (3) cluster of grapes and (4) mosaic pattern. Types two and three were most characteristic of medullary sponge disease.[3]

Pathogenesis

Several theories have been offered to explain the development of sponge kidney. Faulty ontogenetic development (ectasia or dysplasia)[2]; fetal cystic malformation of collecting tubules resulting from deposition of urinary calcium salts[5] or deposition of obstructing uric acid crystals[4]; also possible hamartomatous cystic changes.[5] Why these cystic lesions are confined to the renal medulla has not been explained adequately.

Age and Sex Incidence

The condition was most common in the fourth, fifth and sixth decades according to the Abeshouse[5] review. Ekstrom's series most commonly found patients in the third, fourth and fifth decades.[3] Ekstrom[3] and Lalli[1] found an equal male/female ratio in contradistinction to the Italian literature's 2.5/1 male to female incidence.[5]

Clinical Features

There is no characteristic symptom complex associated with sponge kidney. The condition usually is asymptomatic unless accompanied by infection, calculus formation or obstruction.[5] Pyrah found the clinical presentation could be divided into three groups: (1) Cases not showing calcification but which were recognized by characteristic appearance of the excretory urogram. These may show few or no clinical

symptoms; (2) Cases that presented with nephrocalcinosis and diagnosis were difficult—these patients usually had symptoms; and (3) Cases which presented as clinical examples of renal calculus with symptoms.[8] Most common modes of presentation are recurrent renal colic attacks, hematuria and recurrent attacks of pyelonephritis.[9] Abeshouse[5] in his review most often noted hematuria, (gross more often than microscopic), pyuria, urinary symptoms (urgency, frequency, dysuria, nocturia), pain (dull lumbar or colic) and rarely generalized constitutional symptoms such as anemia, hypertension, fever, edema or electrolyte imbalance. Ekstrom reported symptoms of renal colic, microscopic hematuria, macroscopic hematuria and acute cystopyelitis.[3]

Diagnosis

Excretory urography has generally been considered to give optimal visualization of the lesions. The roentgenographic picture is pathognomonic on intravenous pyelography while retrograde pyelography usually fills out some or none of the cavities in the pyramids.[3] The plain film (KUB) of the abdomen will be negative, unless calculi are present. Cysts usually appear separate and discrete. Occasionally cysts at the tips of the calices or at the fornical angles appear to communicate with the pyelocalyceal system.[5] Specific laboratory tests were not aids in diagnosis. When Ekstrom evaluated his 44 cases, he found that blood urea nitrogen, creatinine clearance, serum calcium, phosphorus, electrolytes and blood alkali reserve were grossly normal. Hypercalciuria and a somewhat decreased concentrating ability were noted.[3]

Differential Diagnosis

In order to establish the diagnosis of medullary sponge kidney, it must be differentiated from a number of similar pathologic states. *Renal tuberculosis* shares the findings of cavities and concretions with medullary sponge disease. Differentiation may be difficult and may rest on specific tuberculosis cultures when pathologic changes are confined to the renal pyramid.[7] Ekstrom et al felt that a lack of knowledge of medullary sponge kidney accounts for most misinterpretation with renal tuberculosis.

Cavities in tuberculosis usually are larger, more irregular, and fill secondarily from the pelvis. Tuberculosis cavities rarely are confined to the pyramids and tuberculous renal units also may show calyceal and pelvic ulceration or stricture, or both. Most difficult differentiation arises when tuberculosis attacks a pre-existing medullary sponge kidney.[3] *"Nephrocalcinosis"*—Albright[10] first described nephrocalcinosis as diffuse calcium deposits in and around the collecting tubules of the kidney in hyperparathyroidism. Many other clinical etiologies for nephrocalcinosis include: renal tubular acidosis (complete and incomplete), pyelonephritis (chronic), milk alkali syndrome, hyperoxaluria, sarcoidosis, chronic glomerulonephritis, hypervitaminosis-D and idiopathic nephrocalcinosis.[11] *"Microcystic form of polycystic kidney disease"* is exclusively a disease found in stillborns and young children. In *adult polycystic kidney disease*, cysts are found throughout the entire renal tissue. Cysts often are found in other viscera and the disease shows a hereditary genetic pattern unlike medullary sponge kidney.[12] *"Polycystic dysplasia of childhood"* usually is unilateral and nonfamilial. Rarely are these patients symptomatic and most reach adulthood if the disease is unilateral.[13] *Calyceal diverticuli* usually involve a small cystic lesion connected to a calyx via a narrow stalk. These may be unilateral, bilateral, single, multiple, localized or diffuse. They fill in the late phases of intravenous pyelography. *Pyramidal cysts secondary to pyelonephritis* rarely are as diffuse as the lesions of medullary sponge kidney. *Renal papillary necrosis* found in diabetics, and phenacetin abusers, has cavities at papillary tips but the stormy, often fatal course is unlike medullary sponge disease.[5] *Tubular stasis* may be seen on early phases of urograms, and when pressure is applied to the ureter. This phenomenon is seen as a structureless cloud of contrast medium in the papilla. Differentiating between stasis and mild degrees of medullary sponge disease is difficult on occasion.[14]

Treatment

Surgery is contraindicated in cases of bilateral medullary sponge kidney. In the absence of serious complications, i.e., stone or infection, nephrectomy or partial nephrectomy usually entails a needless sacrifice of congenitally impaired tissue.[5] Surgical management has been used usually when disease is localized and symptomatic. Selected complete and partial nephrectomy in focal disease are justified in those patients with repeated pyelonephritis or colic from stones[3]

Prognosis

The prognosis in uncomplicated medullary sponge kidney is uniformly good because the condition may persist for many years with no appreciable increase in size of cysts or alteration in renal function.[5] Ekstrom et al, state that prognosis is uncertain in all cases of bilateral disease and grave when infection and free concretions are present.[3] Prognosis varies with the severity

of secondary complications but in the majority of cases is good.

Case Reports

Case 1.—M.B., H24-52-57, a 45-year-old white male, first became aware of his diagnosis when a routine intravenous pyelogram was performed in December, 1970 for evaluation of his hypertension. On July 12, 1971, he was seen in the West Virginia University Medical Center Emergency Room with right ureteral colic. He had undergone bilateral elective vasectomy six weeks prior to the date, but otherwise had no genitourinary complaints.

Physical examination revealed right costovertebral angle pain and two small scrotal nodules resulting from his recent vasectomy.

Laboratory findings: urinalysis revealed a pH of 5.0, numerous red blood cells and 4 white blood cells per high power field. Hemoglobin and hematocrit were normal. Leukocyte count was 13,500, with 4 bands, 72 segmented neutrophils, 16 lymphocytes, and 8 monocytes. Twenty-four hour urinary calcium was within normal limits. Urine culture was sterile. Serum electrolytes, blood urea nitrogen, uric acid, calcium, phosphorus and albumin were normal. His intravenous pyelogram revealed nephrocalcinosis of the renal pyramids (Figure 1a), evidence of renal collecting duct ectasia and a right nephrogram. Delayed films revealed the right ureter obstructed by a small ureterovesical junction calculus (Figure 1-b). On July 16, 1971, he spontaneously passed the calculus but it was not recovered for stone analysis. He was discharged and has been asymptomatic in the clinic follow-up. He has been taking methylene blue tablets three times daily and a follow-up intravenous pyelogram was scheduled for July 1972.

Case 2.—H.B., H14-99-51, a 27-year-old white male, had an episode of gross hematuria in April 1966. He had recently had an upper respiratory infection and a tentative diagnosis of nephritis was made.

Physical examination was normal.

Urinalysis revealed many red blood cells per high power field and acid urine. Blood urea nitrogen, serum electrolytes, fasting blood sugar, serum calcium, phosphorus, 24-hour urinary uric acid and calcium were within normal limits. The hematocrit was 43 volumes per cent, hemoglobin 14.4, and leukocyte count was 5,600 with a normal differential. Electrocardiogram demonstrated sinus bradycardia with complete right bundle branch block. Chest roentgenogram was normal. The hematuria cleared spontaneously. A plain film of the abdomen revealed bilateral nephrocalcinosis (Figure 2a). An intravenous pyelogram showed characeristic "brush stroking" of tubular ectasia bilaterally (Figure 2b). He was followed in clinic and a plain film of the abdomen showed an increase in the size of the renal calculi in December 1967. He has been treated with Mag-

Figure 1a

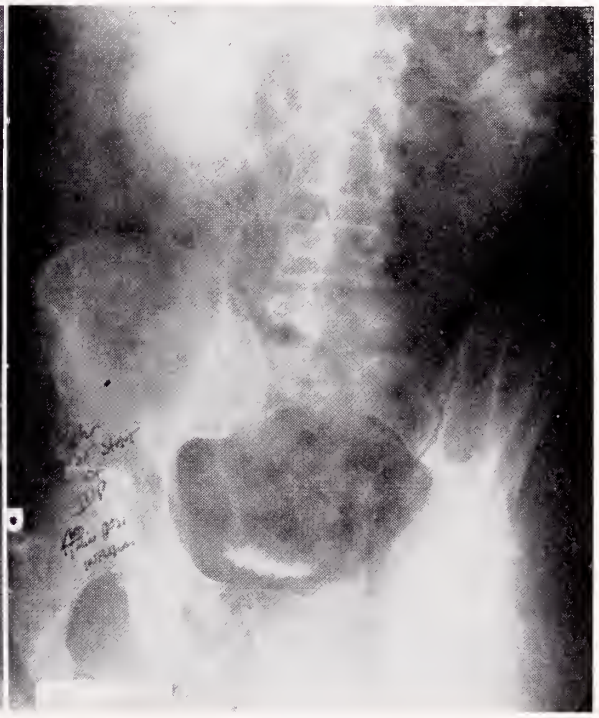

Figure 1b

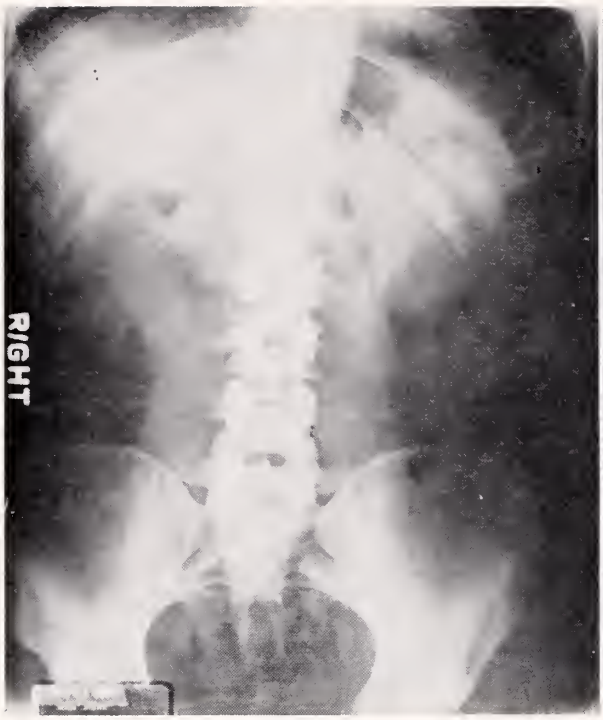

Figure 2a

Figure 2b

nesium Acetate 20 per cent solution, one teaspoon twice daily.

Case 3.—A.H., H26-60-04, a 32-year-old white female, had had recurrent episodes of cystitis since age 10. She denied hematuria but had one episode of fever and right flank pain one year prior to admission. In February 1972, she was transferred to West Virginia University Medical Center for evaluation of nephrocalcinosis. Past medical history is noncontributory. On physical examination, there was mild right costovertebral angle tenderness.

Laboratory findings: normal hemoglobin, hematocrit and leukocyte count. Urinalysis with

Figure 3a

Figure 3b

repeated pH's of 5.0-5.5 and no significant sediment. Blood urea nitrogen, fasting blood sugar, serum calcium, phosphorus and uric acid were within normal limits. A 24-hour urinary calcium was elevated at 314 mg./specimen. Urine culture was negative. A plain film of the abdomen demonstrated nephrocalcinosis confined to the renal pyramids (Figure 3a). Intravenous pyelography suggested dilated collecting tubules (Figure 3b). Cystoscopy and urethral dilatation were performed for urethral stenosis. The patient was discharged on methylene blue tablets three times daily.

Case 4.—E.D., H24-90-33, was a 56-year-old white male who presented to the West Virginia University Emergency Room with right testicular pain and right flank pain. Significant genitourinary symptoms in the past included passing of two ureteral calculi. He had never previously sought medical attention. Family history was negative for calculus disease. On physical examination there was right costovertebral angle tenderness. Genitalia and prostate examination were normal.

Laboratory findings included a urinalysis with pH 5.5, 1-3 red blood cells per high power field, hematocrit 46 volumes per cent, hemoglobin 15.7, leukocyte count 7,100, with a normal differential and a blood urea nitrogen of 22 mg. per cent. Serum calcium was normal on three occasions. Chest x-ray and electrocardiogram were normal. Serum electrolytes were within normal limits and urine culture showed no growth. A plain film of the abdomen revealed faint calcifications in the area of the kidneys (Figure 4a). Intravenous pyelography revealed small dilated collecting ducts and cysts in the renal medulla (Figure 4b).

The patient was admitted to the Urology Service and with hydration and analgesics, he spontaneously passed the calculus. Analysis revealed the stone to be pure calcium oxalate. He was lost to subsequent follow-up.

Summary

A review of medullary sponge kidney disease is presented. The disease process is discussed from a historical, clinical, radiographic and therapeutic viewpoint. Four cases of medullary sponge kidney disease at West Virginia University Medical Center are reported.

A list of references may be obtained by writing The Journal.

Figure 4a

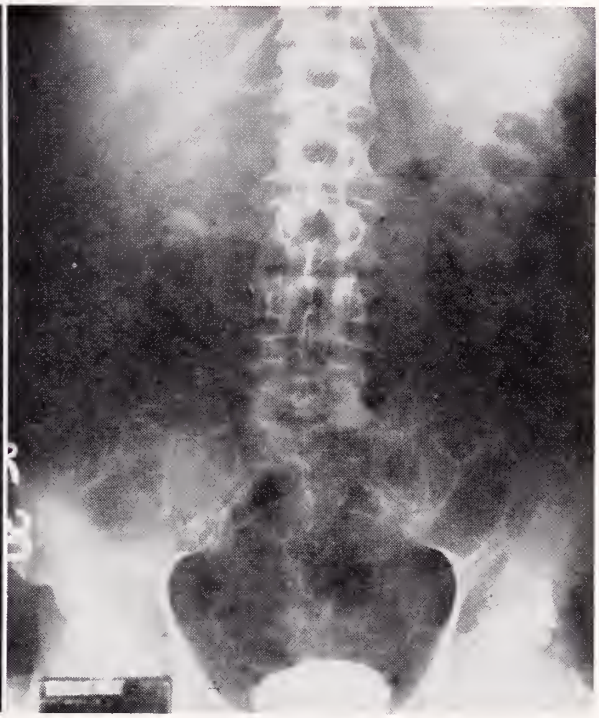

Figure 4b

Strictly Posterior Myocardial Infarction*

(Case Report)

Orlando I. Agnir, M. D.; and C. Vincent Townsend, M. D.

It is extremely difficult, sometimes impossible, to diagnose true and strictly posterior wall myocardial infarction by standard electrocardiography. By definition, this involves a type of infarction whose effective electrical site is located strictly posteriorly and not inferiorly. The abnormal forces tend to be perpendicular to the frontal plane of the body and abnormal Q waves do not appear in any of the conventional leads. Sodi-Pallares points out that the diagnosis of high posterior or posterolateral myocardial infarction is suggested by tall R waves in leads V_1 and V_2, and possibly in lead V_3, and the appearance of septal and of left ventricular morphology in leads to the left of V_3.[1] A tall R wave in lead V_1 also may be found in right ventricular hypertrophy, right bundle branch block, and pre-excitation syndrome (Group A).[2] Although there are no typical electrocardiographic changes in hypertrophic subaortic stenosis, a tall R wave also may be seen in V_1 and V_2, if the muscular hypertrophy involves the anterior end of the ventricular septum including the immediately adjacent left ventricular wall.[3]

In contrast to the electrocardiogram, the vectorcardiogram is almost diagnostic in strictly posterior infarction. The fact must be emphasized, however, that the experience of various investigators in the vectorcardiographic diagnosis of strictly posterior infarction has not as yet been reported in detail.[4]

We would like to report the case of a patient who had angina decubitus, whose electrocardiogram shows a tall R in V_1 *but* with a negative T wave, and whose vectorcardiogram is strongly suggestive of strictly posterior wall myocardial infarction. The suspected vascular and myocardial lesions were confirmed by selective coronary arteriography and during by-pass surgery.

Case Report

The patient is a 54-year-old white male who experienced severe chest pain for the first time on February 17, 1971. This first episode of substernal pain was precipitated by an argument. Physical activities were severely restricted for about two weeks at home but when he returned to work three weeks later, he again experienced severe chest pain. He was observed in his local hospital for two days and was subsequently referred by the second author to the Veterans Administration Center of Martinsburg, West Virginia.

The physical examination was not impressive. He did not even have an atrial presystolic gallop, and he was in normal sinus rhythm. His laboratory examination revealed Type III hyperlipidemia and hyperuricemia. The chest x-ray showed prominence of the cardiac silhouette, and there was no evidence of right ventricular hypertrophy. The electrocardiogram (Figure 1) shows a normal sinus rhythm, PR interval of .14 seconds, a tall R in V_1 and V_2 but a negative T wave in V_1. Serial SGOT, CPK, and LDH remained normal; and follow-up electrocardiograms demonstrated an unstable T wave in V_1—negative, flat, or upright from day to day. He was discharged to clinic follow-up, but in about six months his chest pain slowly progressed to angina at rest.

Selective coronary arteriography demonstrated complete occlusion of the right coronary artery and at least 50 per cent occlusion of the left anterior descending artery. The left circumflex artery was normal. He successfully underwent saphenous vein graft by-pass of the right coronary artery and left anterior descending artery and during surgery healed infarction of the posterobasal area of the heart was observed.

Discussion

The differential diagnoses included the above.[2, 3] Type A Wolff-Parkinson-White syndrome was eliminated because of the normal PR interval and the absence of a delta wave. There

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*This paper was submitted to the Editorial Board while Doctor Agnir was Staff Cardiologist at the Veterans Administration Center, Martinsburg, West Virginia.

was no RSR′ in V_1 and the QRS interval was normal; accordingly, right bundle branch block also was eliminated. He had no physical findings to support hypertrophic subaortic stenosis even after positional provocation and this also was ruled out. The final differential diagnoses therefore rested between right ventricular hypertrophy and strictly posterior myocardial infarction.

In almost all instances of evolved myocardial infarction, the direction of repolarization is away from the site of subepicardial damage. This happens because persistent ischemia in areas adjacent to the infarct allows repolarization to begin in the subendocardial surface. In anterior wall myocardial infarction, the T waves in V_1 to V_4 are negative because repolarization is posteriorly directed. On the other hand, in posterior infarction, the direction of repolarization is anterior, downward and slightly leftward, and therefore the T waves in V_1 to V_4 usually are upright.

Accordingly, we were understandably perplexed when our patient initially had a negative T wave in V_1. There was no reason for him to have right ventricular hypertrophy, and the most logical diagnosis was true posterior wall infarction. A vectorcardiogram (Figure 1) supports the latter. The horizontal and right sagittal planes demonstrate marked QRS loop displacement anteriorly because of loss of posterior forces. The conduction abnormality of the terminal force and the normal counter-clockwise QRS loop in the horizontal plane and normal clockwise QRS loop in the right sagittal plane are consistent with posterior infarction and somewhat against right ventricular hypertrophy. The frontal and horizontal planes, also, do not show

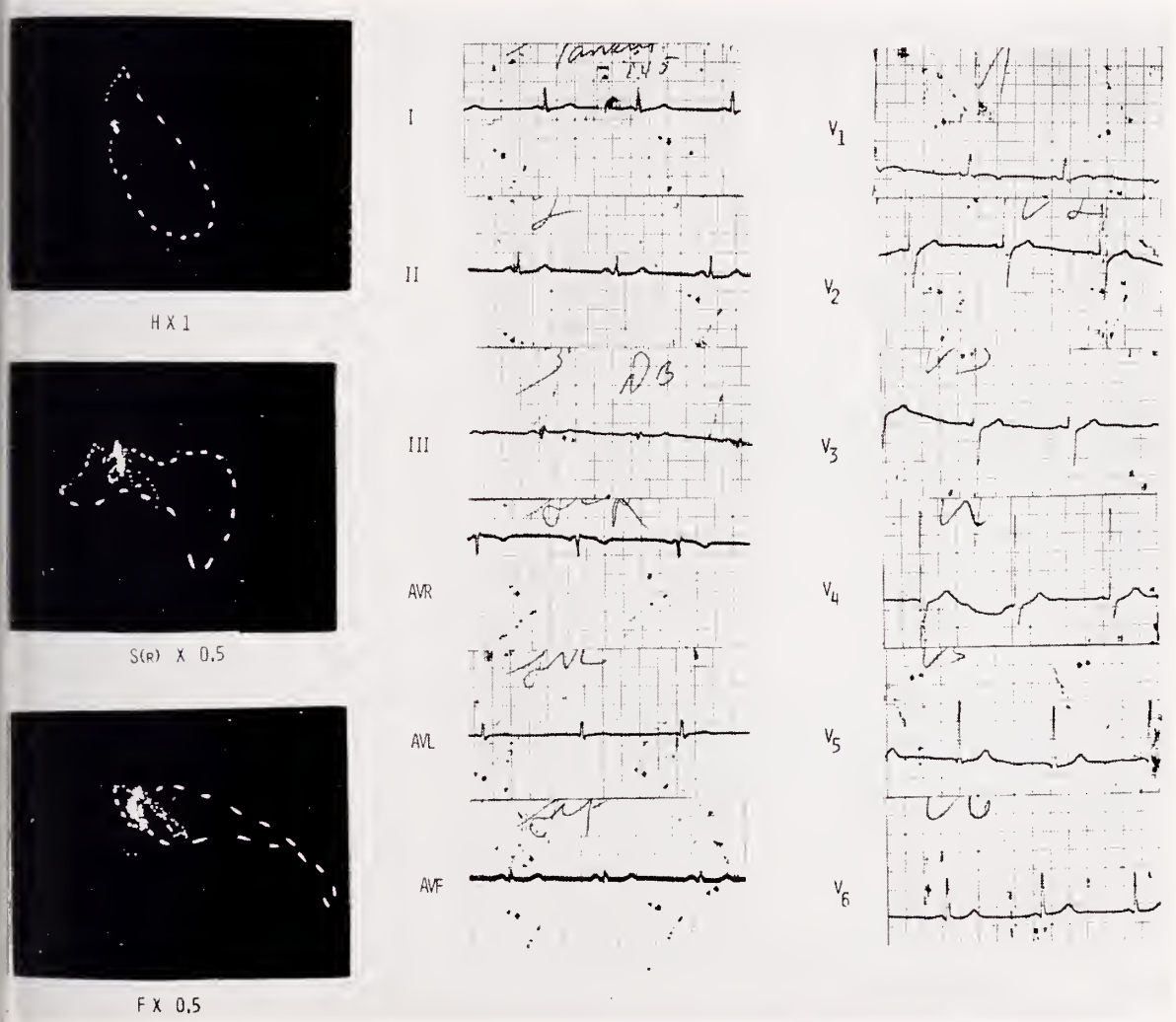

Figure 1. The vectorcardiogram shows an increase in anterior forces as demonstrated in the horizontal and sagittal planes. There is no disturbance in the initial force but there is a terminal conduction delay. There is no terminal appendage of right bundle branch block. The normal QRS loop rotation is preserved: counterclockwise in the horizontal plane and clockwise in the right sagittal plane. The T loop is oriented to the left, anterior and inferior. The electrocardiogram shows a tall R in V_1 and V_2, but a negative T in V_1.

increase in rightward forces. The initially negative and later unstable T wave in V_1 can be attributed to localized anterior wall myocardial ischemia.

Since January, 1970 we have seen 18 other patients whose vectorcardiograms are similar to that of this patient; and we have labeled all as consistent with true posterior wall myocardial infarction. Benchimol states, however, that vectorcardiographic findings consistent with true posterior wall myocardial infarction are seen in about five to 10 per cent of subjects without clinical evidence of coronary artery disease.[5]

Summary

A case of true posterior wall myocardial infarction is reported. The unique electrocardiographic and vectorcardiographic features are discussed in detail, especially in relation to the angiographically demonstrated vascular and myocardial lesions. The vectorcardiogram in this case is a good example of strictly posterior wall myocardial infarction. The normal counter-clockwise QRS loop rotation in the horizontal plane, and the normal clockwise rotation in the right sagittal plane with increase in anterior forces due to loss of posterior forces are the salient features. The most important argument against right ventricular hypertrophy is the lack of increase of forces to the right in the frontal and horizontal planes.

A list of references may be obtained by writing The Journal.

'Tennis Toe'—New Health Problem for Athletes

WEEKEND athletes now have another medical problem to worry about—tennis toe. Tennis elbow has long been known to be a vocational hazard of tennis players. It's similar to pitcher's elbow in baseball.

And now comes tennis toe, mentioned in a report in the current (June) issue of *Archives of Dermatology*, a publication of the American Medical Association. Richard C. Gibbs, M.D., of New York, reports:

"For the past few years I have been impressed by the number of tennis players who complain of pain in one or more of their toes. The pain is associated with the appearance of hemorrhage beneath their toenails. The toe affected is that which extends furthest."

Sometimes this is the big toe, sometimes the second toe, sometimes both extend about the same.

"The explanation I have always held for tennis toe is that in tennis one is frequently stopping abruptly and the forward motion of the body propels the toes into the box toe and tip of the sneakers."

Special Article

What's New In Psychiatry? Plenty!

R. W. Hibbard, M. D.

Psychotherapy of the emotionally disturbed individual has taken many forms over the years. Some kinds of psychotherapy are ridiculously slow, cumbersome and rather inefficient. Psychoanalysis, for example, could appeal only to a small percentage of persons who had considerable free time or who could get away from work several hours a week, to those who had considerable money to pay for it, and lived in a city sufficiently large to support the typical analyst. The psychoanalytic approach of having the patient visit several times a week endlessly recounting his past, analyzing dreams, transference, and the like, was supposed to help. In some cases it undoubtedly did, but considerable research indicates that any method of psychotherapy or no treatment at all will produce a certain percentage of improved patients in time.

In recent years newer types of psychotherapeutic approaches have been found that probably are more effective in producing the same or better results in a shorter period of time. Rational Emotive Psychotherapy is one of the few contemporary psychotherapies that is based upon research-proven learning theories of human behavior. The approach as outlined by its founder, Dr. Albert Ellis, is well covered in his books.[1,2] It is based on the idea that patients really upset themselves not deliberately, but do so by telling themselves irrational ideas about their perceptions which may or may not be objective reality. If patients do not perceive incorrectly and do not tell themselves false or irrational ideas about their perceptions, they will not overreact emotionally to make themselves upset. If they tell themselves irrational beliefs or ideas about what they perceive or misperceive, they tend to overreact with anxiety, depression, anger or other highly undesirable emotions. This therapy is one in which the therapist actively helps the patient to see that his perception of reality must also be objective reality, exposing and focusing on the irrational idea that the patient tells himself about this perception, and then have the patient reprogram himself with appropriate rational beliefs.

The Author

- **R. W. Hibbard, M. D., Clinical Associate Professor of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine; and in the Private Practice of Psychiatry in Huntington.**

The rational belief or statement about a perception will not cause highly undesirable emotions.

Additional mechanisms are used in Rational Emotive Psychotherapy (also called Rational Behavioral Therapy) to facilitate or speed up progress. One of these is specific homework assignments given by the therapist, the patient himself or another patient, if the patient is in group therapy. These are specific things that the patient can do to allow himself to have a corrective emotional experience. Rational Emotive therapists with these techniques reduce a classical 55 minute hour to 30 minutes which would allow them to see almost twice the number of patients in individual psychotherapy. Rational Emotive therapists, in general, are convinced that the more the patient works on reprogramming himself, the more readily he becomes a well-adjusted, efficiently operating person. The patient can be taught this organized approach of self-help, analyzing his own behavior and taking corrective steps when needed. He begins to reprogram his thinking and in a sense actually becomes his own therapist, later avoiding the highly undesirable dependency problem that many patients develop with the conventional therapist.

Group Therapy

Group therapy is another means that can be used to treat a larger number of patients at a reduced fee. In group therapy, six to fourteen patients can be treated by one therapist over a period of one to two hours. Many feel that group experience can begin after only one individual interview. Others feel, however, that it should

begin after a longer period of individual psychotherapy.

Recorded Interviews

One of the new and exciting innovations in psychotherapy is the use of routine cassette tape recording of the interviews. Maultsby,[5] in a recent article, reported that he routinely taped (cassette) the patient's interviews, has them bring their own recording apparatus and then has them listen to their taped interviews several times between therapy sessions. On reflection, most psychotherapists have heard patients report that they remember very little of what the therapist said during the interview because of the patient's own anxiety or depression or both. Little is remembered either correctly or incorrectly. I recently have been attempting to duplicate Maultsby's approach, utilizing Rational Emotive Psychotherapy and am impressed with the superior results. The patient gives early feedback to the therapist with such statements, "I didn't realize I said those things until I listened to the tape and each time I listened to the tape I seemed to hear more." He also makes such statements as, "I must have misunderstood you until I listened to the cassette tape at home and then it became clear." The cost to the patient of buying a portable cassette tape recorder with cassette tapes for recording his own interviews is insignificant compared with the high cost of psychotherapy. It has been my experience that patients offer little resistance to this if they are sincerely motivated to undergo psychotherapy.

Maultsby innovated another help in the form of bibliotherapy and has a number of handout pamphlets* that he has written explaining to the patient the psychotherapeutic approach, how to analyze his own behavior and how to reprogram himself in other facets of therapy that are helpful. Patients rather consistently report that these are extremely helpful to them.

Psychotherapy Speed-Up

There seems little doubt in the minds of most of us that every community in the United States is brimming over with emotionally disturbed persons, and that there usually is an insufficient number of trained professionals in the community to help them. Even with the increasing number of psychologists, counselors, social workers and mental health technicians becoming actively involved in the treatment process, psychotherapy itself can be speeded up by:

1. More therapists treating larger numbers of patients.

2. Increase in the effectiveness and speed of their therapy. By using the Rational Emotive Therapy, homework assignments, bibliotherapy, handout pamphlets, cassette recording of interviews and group psychotherapy, this goal can become closer to realization. All therapists must give faster, more effective help if mental health is to be achieved.

Hopefully, therapists of conventional schools of psychotherapy will abandon the conventional idea that patients have to come to see them one or more times a week for about an hour for long periods of time to get better. There are more effective techniques to help patients that are easily learned and applied by any therapist who is willing to grow and change. Rational Emotive Therapy is one that offers, in my opinion, the most promise.

***These are available for purchase by writing Maxie C. Maultsby, Jr., M. D., Director of Psychiatric Outpatient Department, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.**

A list of references may be obtained by writing The Journal.

So, What Else is New?

If you think your mail delivery is erratic, you are right. Because complaints of late deliveries of AMA publications have increased in recent months, the AMA conducted a nation-wide random sample survey of the delivery of the April 16 issue of *JAMA*. The magazine was mailed April 12 from the printer in Milwaukee and delivery dates ranged from April 14 to April 26. The April 14 delivery date was in Seattle, 1,958 miles from Milwaukee. The April 26 delivery was in Chicago, just 87 miles away!

X-Ray Case of the Month

Unusual Intra-Abdominal Calcification

Catalino B. Mendoza, Jr., M. D.; C. S. Krishna Murthy, M. D.; Gabriel Al-Hajj, M. D.; Erlinda DeLaPena, M. D.; and Raymond C. Bonnabeau, Jr., M. D.

A 79-year-old white male, (R. S.), was admitted on January 6, 1973, to the Clarksburg Veterans Administration Hospital with a history of vomiting coffee-ground material for three days prior to admission. At the time of admission the patient, who had a 20-year history of diverticulosis of the colon, was in a state of shock.

Physical examination revealed an acutely ill, elderly patient with a blood pressure of 90/0, a pulse of 96, a temperature of 100.4°, and respirations of 24 per minute. There were no cardiac murmurs and no rales in the lungs. Palpation of the abdomen revealed minimal tenderness in the right and left lower quadrants. There was no rigidity and the bowel sounds were hypoactive. Tarry stools were present in the rectum. These were guaiac positive.

Roentgenographic examination of the abdomen (supine and erect views) taken on admission were interpreted as follows: "A laminated calcified rounded density measuring about two centimeters is seen in the right side of the pelvis. This morphologically has the appearance of a gallstone; however, its position is unusually low and there is no evidence of any free air in the biliary tracts to suggest a cholecysto-intestinal fistula with exclusion of the stone. It is possible that this unusually low-placed, rounded density could be a gallstone which has escaped from the gallbladder following rupture. A similar situation could be produced by an appendiculolith which has undergone calcification. On many of the films which were taken subsequently, this seems to be movable over a wide range. There is some distention of the loops of the small bowel, not sufficient to call obstruction. This could be reflex in origin and there is a suggestion of thickening of the bowel wall loops indicating some peritoneal reaction. *Conclusion*: Unusually low calcific density."

Discussion

The appearance of the laminated calcific shadow suggested that it was confined in a closed space. It also suggested a gradual increase in size. Normally, common sites for such calcifications in this area might be the appendix or the gallbladder. Rare sites for such calcified masses

The Authors

- **Catalino B. Mendoza, Jr., M. D.; C. S. Krishna Murthy, M. D.; Gabriel Al-Hajj, M. D.; Erlinda DeLaPena, M. D.; and Raymond C. Bonnabeau, Jr., M. D., all from the Departments of Surgery, West Virginia University School of Medicine, Morgantown; and Veterans Administration Hospital, Clarksburg, West Virginia.**

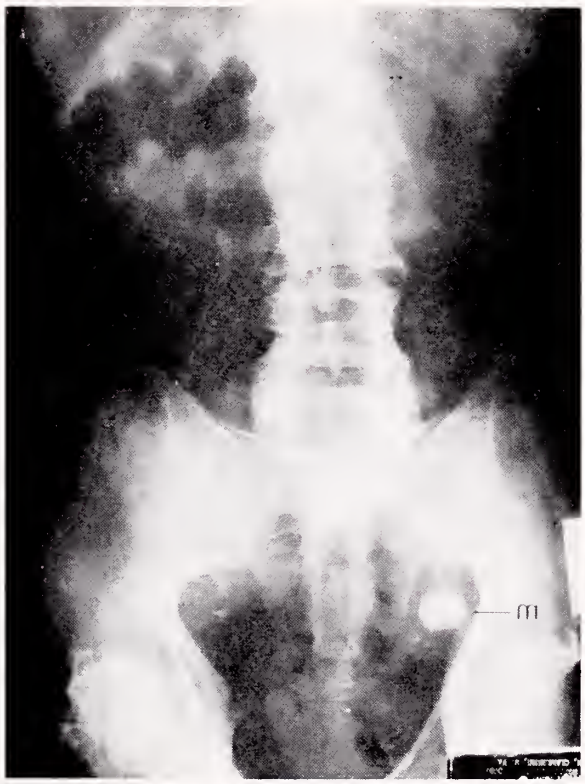

Figure 1. Laminated calcified density (M) at the right lower pelvis.

have been found. These would include calcific masses in a Meckel's or a bladder diverticulum. Still rarer causes include diverticulum of the small or large bowel with fecoliths undergoing calcification and, in women, dermoid cysts. Similar instances of calcification in Crohn's disease have been reported.[1] In children, the presence of such a calcification in this area is highly suggestive of a gangrenous appendix.[2]

Treatment in this patient consisted of fluid and electrolyte replacement, together with blood and antibiotics, as preparation for surgery. However, despite all measures, the patient did not respond and expired on January 7, 1973.

Limited postmortem examination disclosed a perforated Meckel's diverticulum containing a calcified fecolith.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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ffeine gr. ½.

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one of the many things you need in an anticholinergic.

Pro-Banthīne is provided in several different dosage forms and combinations which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthīne® (propantheline bromide) reduces gastric secretory volume and resting total and free acid.

"Sustained" action—Pro-Banthīne P.A.® (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized.

High-level anticholinergic activity is maintained all day and all night in most patients with only two tablets every eight hours.

"Analgesic" action—Pro-Banthīne helps to control the acid-spasm-pain complex.

A "diagnostic tool"—Pro-Banthīne may be used parenterally to immobilize the duodenum for more revealing roentgenographic appraisal through hypotonic duodenography.

Pro-Banthīne is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measures.

Vigorous anticholinergic action — Pro-Banthīne® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthīne® Half Strength, 7.5-mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Indications: Pro-Banthīne is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthīne.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthīne P.A.—Each tablet of Pro-Banthīne P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthīne 15 mg. should be observed.

How Supplied: Pro-Banthīne is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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a good option in peptic ulcer

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

GETS THE WATER OUT IN EDEMA

BRINGS DOWN BLOOD PRESSURE IN HYPERTENSION*

SPARES POTASSIUM IN BOTH

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

*Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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With the means at hand drastically reduce the number deaths each year from uterine ncer, we have embarked on a tionwide, life-saving program. goal is a Pap test by 1976 for ery woman 20 years or older whom the test is applicable, d for younger women at risk. ı ambitious program, doctor, d one which can only be alized with your help.

We are faced with these cts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

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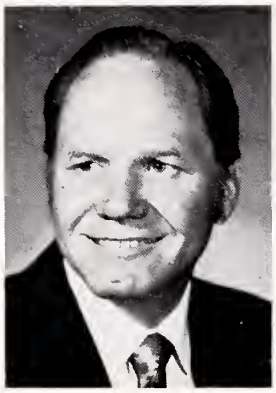

A message from . . .

The President

HEALTH CARE — AN INALIENABLE RIGHT?

GIVE me Health Care or Give Me Death! Does that sound like a slogan that would make a patriot, another Patrick Henry, out of me?

The American Declaration of Independence states that all men have certain inalienable rights; among these are Life, Liberty and the Pursuit of Happiness.

The American Bill of Rights guarantees certain Civil Liberties to citizens of the United States, and also forbids Congress to adopt laws that would violate those Civil Liberties. In none of these respected documents is Health or Health Care mentioned.

Life, Liberty and the Pursuit of Happiness, and the Civil Liberties, Freedom of Religion, of Speech, of The Press, of Assembly and others are rather vague and permissive, requiring personal volition of the "Rightee" and no action on the part of others, certainly not a personal service to the "Rightee."

The "Inalienable Right to Health Care" does require action on the part of the provider of that care and perhaps forfeits some of the above mentioned "Liberty and Pursuit of Happiness" by the provider.

"Right" requires that health care be available at all times to all people without restriction. How much effort on the part of the "Rightee" is required in obtaining the health care? What quality of health care should be available and how available? A family physician 10 miles or 20 minutes away might not be good enough to satisfy the criteria.

Proposals have been made that health personnel should be required to serve where they are "Needed." Who determines this need? Is this not a form of servitude? The 18th Amendment to the Constitution states that involuntary servitude, except as punishment for a crime, should not exist in the United States. When did the Practice of Medicine become a crime?

Can this "Right" cause a minority group—the physicians—to lose another inalienable right, Liberty or Freedom?

Worthy W. McKinney M.D.

W. W. McKINNEY, M. D., *President*

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EDITORIALS

"THE THOMAS L. HARRIS ADDRESS"

A precedent setting event of our 1973 Convention at The Greenbrier will be the institution of "The Thomas L. Harris Address," keynoting the opening session. A bequest in the will of the late Dr. Thomas L. Harris establishes a trust fund, the income of which is to be used to enhance our members' interest in the annual meetings.

During his lifetime Doctor Harris attended these meetings faithfully and was a firm believer in their value to the practicing physician. It was characteristic of him to wish to extend the quality of these sessions in order to further benefit his fellow physicians beyond his lifetime.

The Executive Committee of the Association has decreed that the funds shall be spent to provide an outstanding speaker to keynote the clinical program, and that this address shall be termed, "The Thomas L. Harris Address," so that the name of Doctor Harris will be enshrined at our meetings as long as the Association shall survive.

Doctor Harris was President of the West Virginia State Medical Association in 1945. It was a strenuous and difficult year because of the many problems created by the massive movement of our physicians to the Armed Forces. His background of service to his county and state societies in many capacities proved equal to this task. Until his death on July 11, 1972, he continued to provide active service and dedication to West Virginia Medicine.

Doctor Harris served West Virginia University for many years, first as a member and later as Chairman of the Board of Governors. He was a

Thomas L. Harris, M. D.
(1889-1972)

founding father of the School of Medicine and had an active role in planning and staffing the School. He will always be remembered for the support he gave this great institution.

He was imbued with a strong sense of responsibility of the physician to his profession and his community. He exemplified this in countless ways; by his generous support of civic betterment programs, and the unstinted giving of his time and money to the underprivileged. Many children received their education through his benevolence.

The Association is grateful to Doctor Harris for this continuing contribution to West Virginia Medicine. Our Association will be better for this annual address. Carefully selected speakers from anywhere in our country can now be invited to give a discourse on any subject in Medicine, related sciences or the humanities.

"The Thomas L. Harris Address" will become an increasing attraction not only to our members, but to all those interested in the health and welfare of West Virginia.

The first of "The Thomas L. Harris Addresses" will be given by the Hon. Arch A. Moore, Jr., Governor of the State of West Virginia, at the opening of the first general scientific session at The Greenbrier on Thursday morning, August 23.

PROSTAGLANDINS

An interesting development is taking place in biomedical research which concerns the physiologic and pharmacologic activities of the prostaglandins. Indeed, it is expected that within a relatively short time some of the varieties of this compound will have important clinical usage.

Observations on the pharmacologic effects produced by semen and prostate extracts were made as early as 1913. It was not until 1934, however, that under the leadership of von Euler, the Swedish scientist, that the prostaglandins began to receive significant recognition. He noted that semen and prostate extracts lowered arterial blood pressure on intravenous injection, and observed further that they also caused stimulation of isolated strips of the intestine and uterus Since 1934 a great deal of work has been done by von Euler and his colleagues on the prostaglandins. It was von Euler who gave prostaglandin its name, an unfortunate one, because prostaglandin has a widely distributed bodily origin.

The principal naturally occurring compounds are designated as E and F varieties; these letters are not to be interpreted as "excitatory" or "failure to excite." E form was designated because it is more soluble in ether and F form because it is soluble in phosphate buffer solution (phosphate is spelled with an F in Sweden). It will be seen that in some instances these two forms act differently on the body.

Presently there is considerable confusion about the action of prostaglandins, partly because there are several varieties and also because the compounds do not always work the same in human beings as they do in animals. It must be emphasized that much of the research work has been done on laboratory animals. A few examples may be given to show the complexity of the action of prostaglandin compounds. The E form compound produces a reduction in tension in blood vessels while, on the other hand, the F form causes constriction of blood vessels and can cause hypertension. In the stomach E form inhibits gastric secretion while F form causes nausea and vomiting; in the intestine both E and F forms cause increased peristaltic action and so decreases travel time accordingly.

These examples are sufficient to show the great complexity of the action of the prostaglandins. Obviously much more research work is needed to refine the action of the various compounds. It is also obvious that the physiologic and pharmacologic action of these compounds may well have important applications to medicine. It has been suggested that the most promising possibilities for clinical use of prostaglandins lies in the treatment of peptic ulcer, in controlling hypertension and in the field of obstetrics and gynecology. For example, in obstetrics both the E and F compounds will induce explosive contractions of the uterus in any trimester. The probable use of E compounds in peptic ulcer by inhibiting gastric secretion and in hypertension by dilating arterial blood vessels are self evident.

If the prostaglandin preparations prove to be of value in the conditions just mentioned, they will be of great benefit in helping relieve common, but unfortunately serious, illnesses of mankind. It is to be hoped that this will soon obtain.

HOSPITALS AND FIRE STATIONS

The Cost of Living Council was recently told that hospital care costs went up 11.6 per cent last year. In this instance, 11.6 per cent adds up to slightly more than $745 million.

Our first reaction, in effect was to say, "So what else is new?" For more years than we can count, hospital care costs have been going up and up and up and up—and never by modest amounts. To compound

the problem, no one seems to know why such costs have gone up and up and up and up. If you ask a dozen people, all of whom might be expected to know, you may get a dozen different answers. We can remember being told that spiraling hospital care costs were caused by: (a) too few beds; (b) union demands; (c) higher minimum wages; (d) more sophisticated and costly equipment; (e) the need for more specialized personnel, etc., etc., etc. Having no desire to quibble, we won't argue with any of the reasons — even though a few of them could well be debated.

What no one points to, or at least not openly, is the very good possibility that hospital care costs have gone up and up and up and up because, quite simply, there has been no reason for them *not* to. If everyone in town needed a glass of lemonade from time to time—and the only available lemonade came from a single stand, it would not be unrealistic to expect that the price of lemonade might get slightly out of line. It would get even more out of line if the city fathers then came along and said, "You can charge as much as you want for lemonade because we'll help pay for it."

In other words, the community hospital is often the town's only nongovernmental enterprise that has little or no competition, does not pay an income tax, can count on a continuing subsidy (direct or indirect) and does not have to show a profit. Given those circumstances, the price charged for any goods or service would be likely to increase—dramatically and endlessly.

The hospital thus ends up chasing its tail. The more money it needs, the more money it gets; the more money it gets, the more money it needs. The net result—and the interminable result—is that hospital care costs go up and up and up and up.

Furthermore, there's no effective way for patients to "shop" hospitals. Most patients go where their doctor tells them to go. They may go from used car dealer to used car dealer but they don't go from hospital to hospital—looking for lower double-room rates.

So again, hospital care costs have gone up for a variety of reasons but for *one* overriding reason—there has been no reason for them not to. Furthermore, and this may be overstating the obvious, they will continue to go up until there *is* a reason for them not to. Such a reason might exist, at least in part, if hospitals operated in a slightly more competitive environment and without knowing that there will be someone there with a handout every time it's needed. Hospitals provide an essential community service and deserve community support—but so do fire stations (and the cost of putting out a fire didn't go up 11.6 per cent last year). — *Reprinted from the May issue of American Family Physician, through the courtesy of Mr. Walter H. Kemp, Managing Publisher.*

Lean Diets and Atherosclerosis

Findings during the testing of a new drug have revealed that low-fat, low cholesterol diets can reverse the effects of advanced atherosclerosis disease. This disease causes a loss of functioning power of the arteries because of cholesterol deposits.

University of Chicago researchers conducted the study in which 17 Rhesus monkeys received diets which included butter fat, coconut oil and cholesterol for one and a half years.

The experiments were performed to find out the effects of high levels of fat and cholesterol on the aortic surface, and to determine if the oral agent designated W-1372, reduced the severity of the disease.

At the end of the 18 months, the monkeys were divided into groups. Five were examined to assess the severity of the disease. Two groups of five each were then switched to low-fat, low-cholesterol diets for another 18 months. The remaining monkeys were continued on the original diet. One of the groups also received the drug being tested along with their lean diet.

At the end of the second 18 months, the two groups of monkeys on the lean diet experienced a drastic reduction in their cholesterol levels. The five monkeys who received the oral drug showed no more of a decrease than the five that did not receive the agent. The remaining monkeys on the original diet had lesions covering over 95 per cent of the aortic surface area.

The researchers noted that these findings are preliminary because the evaluation does not include the monkeys' coronary arteries. Additional results will be reported later this year.

The National Society for Medical Research continues to support this kind of animal research. Only through investigation will science be able to safely produce results which will benefit not only this generation, but generations yet unborn.

Tumor Immunotherapy Registry

The National Cancer Institute has established an International Tumor Immunotherapy Registry to serve as a center for collection, storage and exchange of information on immunological methods of treating cancer.

The registry will record physicians' experience with immunotherapy for human cancer, including methods of administration, results of the treatment, and possible side effects. It will be kept up-to-date by periodic progress reports from the physicians, who will in turn receive newsletters containing summaries of the most recent information.

GENERAL NEWS

Program Completed for Annual Meeting At The Greenbrier, Aug. 22-25

Plans have been completed for the 106th Annual meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 22-25.

The Program Committee announced that 10 prominent physicians and surgeons will present papers at the three general scientific sessions on Thursday, Friday and Saturday mornings, August 23-25.

Dr. Richard W. Lindsay

Dr. Wyn Rhys-Jones

The session on Thursday morning will be devoted to a "Symposium on New Concepts in the Medical and Surgical Treatment of Coronary Artery Disease" and the Saturday morning session to a "Symposium on Family Practice."

It was announced previously that Dr. James L. Grobe of Phoenix, Arizona, President of the American Academy of Family Physicians, would be one of the participants in the "Symposium on Family Practice." The other speakers will be:

Dr. Richard W. Lindsay, Chairman of the Department of Family Practice at the University of Virginia School of Medicine.

Dr. Wyn Rhys-Jones, Department of Family Practice at the University of Ottawa and the Ottawa Civic Hospital.

Dr. Clark K. Sleeth, Acting Chairman of the Department of Family Practice at the West Virginia University School of Medicine.

Richard W. Lindsay, M. D.

Dr. A. Thomas McCoy of Charleston, Chairman of the Program Committee, announced that Drs. Richard W. Lindsay and Wyn Rhys-Jones had been selected to round out the program for the Saturday morning "Symposium on Family Practice."

Doctor Lindsay was graduated from Cornell University and received his M.D. degree in 1960 from New York Medical College. He interned at Buffalo General Hospital in Buffalo, New York, and served a fellowship in internal medicine at the University of Virginia Hospital, 1961-62. He was engaged in general practice for a short time in Old Forge, New York.

He returned to the University of Virginia Hospital in 1962 and served a residency in internal medicine at that Hospital until 1966. He served from 1967 to 1969 as a Major in the Medical Corps of the United States Army.

Doctor Lindsay returned to the faculty at the University of Virginia in 1969 and served as Assistant Dean for two years before accepting his present position. He is a member of the Albemarle County Medical Society, Alpha Omega Alpha and the Society of Teachers of Family Medicine. In 1971 he was named Traveling Fellow of the Royal Society of Medicine and investigated teaching in ambulatory clinics in England.

Dr. Wyn Rhys-Jones

Dr. Wyn Rhys-Jones, a native of Stirling, Scotland, was graduated from Llandovery College in West Wales and received his medical degree in 1959 from Trinity College in Dublin. He also received a degree in public health from the University of Toronto in Canada in 1967.

He served as a house surgeon at the Royal Gwent Hospital and St. Wollos Hospital in the United Kingdom. He also interned and served a residency at Grace Hospital in Winnipeg, Manitoba, Canada and from 1961 to 1968 he served as a medical officer with the Department of National Health and Welfare. Since 1969 he has served as a member of the staff of the Family Practice Unit at the University of Ottawa—Ottawa Civic Hospital and as a major part-time Assistant Professor in the Department of Epidemiology and Community Medicine at the University of Ottawa.

Doctor Rhys-Jones is currently serving as President of the Ottawa Regional Chapter of the College of Family Physicians of Canada and is a member of the Society of Teachers of Family Medicine. He also is a member of the Ontario Medical Association, Canadian Medical Association and the Primary Care Research Group of North America.

First General Scientific Session

Dr. William H. Carter of Charleston, a member of the Program Committee, will serve as moderator for the "Symposium on the New Concepts of the Medical and Surgical Treatment of Coronary Artery Disease." The participants will include:

C. Richard Conti, M. D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine. Subject: "Medical Therapy of Angina Pectoris."

James J. Morris, Jr., M. D., Associate Professor of Medicine, Duke University School of Medicine. Subject: "Angiographic and Hemodynamic Aspects of Coronary Artery Disease."

William H. Muller, Jr., M. D., Professor and Chairman of the Department of Surgery, University of Virginia School of Medicine. Subject: "Surgical Aspects of Coronary Artery Disease."

Second General Scientific Session

The speakers at the second general scientific session on Friday morning will be as follows:

Theodore M. King, M. D., Professor and Director of the Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine. Subject: "Abortifacients—Efficacy and Untoward Effects."

Alvin L. Watne, M. D., Professor of Surgery, West Virginia University School of Medicine. Subject: "Colon Polyposis and Colon Cancer."

John A. Kirkpatrick, Jr., M. D., Professor of Radiology and Pediatrics, Temple University School of Medicine. Subject: "Respiratory Obstruction in Differential Diagnosis and Diagnostic Techniques."

Afternoon Meetings

Meetings of section and affiliated societies will be held on Thursday and Friday afternoons. Many of the guest speakers have accepted invitations to present papers at the afternoon meetings and their subjects will be announced in the August issue of *The Journal.*

Honor Guests

Elsewhere on this page of *The Journal* announcement is made that the Hon. Arch A. Moore, Jr., Governor of the State of West Virginia, has accepted an invitation to deliver the keynote address at the opening of the first general scientific session on Thursday morning. Governor Moore will deliver "The Thomas L. Harris Address" which was established this year in memory of the late Doctor Harris who served as President of the State Medical Association in 1945.

Dr. Russell B. Roth of Erie, Pennsylvania, President of the American Medical Association, will be the principal speaker at the first session of the House of Delegates on Wednesday afternoon, August 22.

Mr. Mortimer M. Caplin, who served for four years as United States Commissioner of Internal Revenue, will speak at an open meeting which will be held on Thursday afternoon, August 23. Mr. Caplin is senior partner in the law firm of Caplin & Drysdale of Washington, D. C., and his remarks will involve matters of interest to practicing physicians and the Internal Revenue Service.

Members of the Association and the Woman's Auxiliary also will pay tribute to Dr. Carl A. Hoffman of Huntington whose term of office as President of the American Medical Association came to an end during the AMA meeting in New York City in June.

Governor Moore To Deliver First 'Thomas L. Harris Address'

Gov. Arch A. Moore, Jr., has accepted an invitation to be an honor guest at the 106th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 22-25.

Gov. Arch A. Moore, Jr.

Dr. A. Thomas McCoy of Charleston, Chairman

(Continued on Page 186)

Business Meetings

The Pre-Convention Meeting of the Council will be held on Wednesday morning and several of the sections and affiliated societies have indicated they plan to conduct business sessions in conjunction with the scheduled afternoon meetings. The first session of the House of Delegates will be held on Wednesday afternoon and the final session on Saturday afternoon, August 25.

Room Reservations Pass 550 Mark

The management at The Greenbrier has indicated that the number of room reservations for the 106th Annual Meeting in August has passed the 550 mark as this issue of *The Journal* went to press. It is anticipated that more than 700 hundred persons including physicians, their wives and guests will be in attendance. Everybody planning to attend the Convention should contact the Reservation Manager at The Greenbrier as soon as possible.

The complete scientific program and other scheduled functions during the Annual Meeting will be published in the August issue of *The Journal.*

Governor Moore

(Continued from Page 185)

of the Program Committee, announced that Governor Moore will be the keynote speaker at the first general scientific session on Thursday morning, August 23. Governor Moore will deliver the first of "The Thomas L. Harris Addresses" which was established as a result of a bequest in the will of the late Dr. Thomas L. Harris.

Doctor Harris, who served as President of the State Medical Association in 1945, established the trust fund in an effort to enhance the quality of the programs for future annual meetings of the Association (See lead editorial on Page 181).

Governor Moore's address will follow opening remarks by Doctor McCoy and Dr. Worthy W. McKinney of Beckley, President of the West Virginia State Medical Association.

Governor Moore was born in Moundsville and educated in the public schools of Marshall county. He was graduated from West Virginia University and received his Bachelor of Law (LL.B.) degree in 1951.

During World War II, Governor Moore served as a Combat Sergeant in the United States Army. He was the recipient of the Purple Heart as the result of severe wounds received on the battlefield.

Governor Moore was elected to the West Virginia House of Delegates in 1952 and in 1956 he was elected to the first of six consecutive terms in the United States Congress. During his service in Congress he became a ranking Republican member of the House Judiciary Committee and several other influential committees.

He was elected the 28th Governor of West Virginia on November 5, 1968, and was inaugurated on January 15, 1969. In the 1972 General Election, he became the first West Virginia Governor to successfully succeed himself in office for another four-year term.

Governor Moore is married to the former Shelley Riley and they have three children.

Dr. Karl J. Myers Honored By University of Maryland

Dr. Karl J. Myers of Philippi was honored at a meeting of the Medical Alumni at the University of Maryland School of Medicine on May 31. He was presented a certificate in recognition of his 50 years in the active practice of medicine.

Doctor Myers was engaged in general practice in Philippi for 15 years prior to receiving training in radiology. He has limited his practice to radiology since that time and has been associated with The Myers Clinic and Broaddus Hospital in Philippi during his entire medical career.

Mrs. Myers accompanied her husband to Baltimore for the presentation. Their two children, Dr. Evangeline M. Poling and Dr. Karl J. Myers, Jr., also practice medicine in Philippi.

Dr. Russel Kessel (second from right) of Charleston was congratulated by officers and Board members of the Kanawha Council of the Navy League of the United States for an Exceptional Service Award conferred upon him by the Selective Service System. The recognition came at a dinner at which the Council was host to Rear Admiral Lloyd W. Moffit (left), of Washington, D.C., Director of Navy Space Programs and Satellite Program Coordinator. Others pictured are Mr. R. P. DeVan of Charleston (second from left), President of the Council, and Lieutenant Nelson L. Vincent, USN, Commanding Officer of the U. S. Naval Reserve Training Center at South Charleston. Doctor Kessel is a former President of the Kanawha Council.

Selective Service Presents Award To Dr. Kessel

Dr. Russel Kessel of Charleston, a Past President of the West Virginia State Medical Association, has received the U. S. Selective Service System's Exceptional Service Award.

He was cited for "outstanding service of exceptional benefit to the nation and the Selective Service System" in serving as Chairman of the West Virginia Volunteer Medical Advisory Committee to Selective Service over a 22-year period beginning in 1950.

Doctor Kessel's service, the citation reads, "contributed immeasurably to the successful operation of the Selective Service System," and "earned for him the deep and lasting gratitude of his professional associates, his state and his country."

Radiation Congress in Washington, D. C.

The International Radiation Protection Association [IRPA] will hold its Third International Congress in Washington, D.C., September 9-14, 1973, at the Washington-Hilton Hotel. IRPA is an organization of professional health physics and radiation protection societies in some 60 nations. Members in affiliated national societies automatically attain membership in IRPA.

In the United States, the national society of IRPA is the Health Physics Society [HPS]. The HPS and its Baltimore-Washington Chapter will be hosts for the Congress.

Inquiries about the Congress may be directed to Mr. Robert A. Catlin, Congress Secretary-General, U.S. Atomic Energy Commission, Washington, D. C. 20545.

Federal Health Expenditures Exceed $42 Billion

Federal health expenditures in the current fiscal year will exceed $42 billion—an increase of $2 billion over the previous fiscal year, according to The American Medical Association.

The report on *Federal Medical-Health Appropriations,* prepared by the American Medical Association's Department of Governmental Relations, offers a unique view of the federal government's overall involvement in health and health related activities.

In most cases, supplemental appropriations for specific programs are not included, meaning that actual figures are higher than presented. The bulk of the report deals with appropriations, but a table also shows estimated spending this fiscal year on trust fund and other expenditures for disability in various programs including Social Security, Veterans Administration, military disability retirement and railroad retirement.

Considering appropriations alone, the total for the present fiscal year is $28.3 billion, compared with $26.5 billion the previous year. Federal Medicare expenditures of $9.5 billion are included although $6.6 billion come from the Social Security Medicare trust fund for Part A or hospital benefits. The Medicare law requires these funds to be treated as appropriations by Congress.

The Health, Education, and Welfare department, of course, leads the list in appropriations—$18.1 billion compared with $17.6 billion the year before. In order come the Veterans Administration, $2.9 billion; Defense, $2.8 billion; Environmental Protection, $2.3 billion; Federal Employes Health Insurance, $604 million; Agriculture, $362 million (animal and plant health inspection, etc.); State, $258 million; and OEO, $150 million.

Sero-Diagnosis of Cancer Symposium

The First Invitational Symposium on the Sero-Diagnosis of Cancer, co-sponsored by the Laboratory Service, Naval Hospital, Bethesda; the College of American Pathologists, (CAP); the American Society of Clinical Pathologists (ASCP); and the Armed Forces Radiobiology Research Institute (AFRRI), will be held Saturday, September 29 in the Naval Hospital Auditorium, National Naval Medical Center, Bethesda, Maryland 20014.

The objectives are: To provide a forum for disseminating information on the current status of the sero-diagnosis of cancer, to allow interested investigators to present the results of their investigations and to share information on techniques and methodologies; to acquaint clinicians with the availability, usefulness and limitations of these techniques; to publish the formal presentations for inclusion in the medical literature; and to provide an opportunity for holding wet workshops in diagnostic techniques and methodologies.

Dr. Bateman Named Vice President Of American Psychiatric Assn.

Dr. Mildred Mitchell-Bateman, Director of the West Virginia Department of Mental Health, was elected Vice President of the American Psychiatric Association at its meeting recently in Honolulu, Hawaii.

Mildred M. Bateman, M. D.

Doctor Bateman, who has held her present position since 1962, is a native of Georgia. She received her undergraduate degree from Johnson C. Smith University at Charlotte, North Carolina, and her M. D. degree in 1946 from the Woman's Medical College of Pennsylvania. In 1955, she completed a three-year Psychiatric Residency and Fellowship in The Menninger School of Psychiatry at Topeka, Kansas. Doctor Bateman received a Distinguished Alumna Award of the Menninger School of Psychiatry from the Alumni Association in 1964. In 1967, she was recipient of the Annual Citation given by the National Board of the Woman's Medical College of Pennsylvania—the first time the award had been given in the field of mental health and the first time a graduate of the school had been selected.

Doctor Bateman is certified by the Board of Neurology and Psychiatry for the Practice of Psychiatry.

Special Assignments

Doctor Bateman is a member of the Mental Health Committee of the West Virginia State Medical Association, a Member of the Board of Trustees of The Menninger Foundation, a Member of the Board of Directors of the National Association for Mental Health and Chairman of the Research Committee for the Association, and Member at Large of the Board of Directors of the Family Service Association of America.

A member of the Kanawha Medical Society and the state and national medical associations, Doctor Bateman also is a member of the Academy of Religion and Psychiatry, the Council on Mental Health of the AMA, the Commission on Mental Illness and Mental Retardation, Southern Region Education Board; the Group for the Advancement of Psychiatry, and the West Virginia Medical Society, Inc.

Doctor Bateman first came to West Virginia in 1947, as Clinical Director at Lakin State Hospital. She twice interrupted her career there for additional training out of the state, returning to Lakin in 1958 as Superintendent. In 1960, she became Supervisor of the Division of Professional Services for the Department of Mental Health, holding that post until her appointment as Director in 1962.

Participating in a site survey of the Beckley Appalachian Regional Hospital's Continuing Medical Education Program in May were, seated, from left, Dr. William E. Gilmore, Parkersburg, Chairman of the survey team; Dr. Ross L. Egger, Daleville, Indiana; and Dr. Mary Lou Lewis, Charleston; standing, from left, Dr. Rutledge W. Howard, Chicago; and Dr. Richard G. Starr, Beckley.

Medical Education Accreditation Granted By State Association

The West Virginia State Medical Association last month granted its first American Medical Association accreditation for a hospital Continuing Medical Education Program. Under a new state accreditation procedure developed within the past year and approved by the AMA, the State Medical Association now has the authority to act as an accrediting agency for the AMA.

The Beckley Appalachian Regional Hospital was granted a one-year, provisional accreditation for its CME program by the Association's Committee on Medical Education and Hospitals, meeting in Charleston on June 17 at the Heart-O-Town Motor Inn. This committee, working with the Association staff, has the responsibility for conducting the state accreditation program and the authority for granting approval or disapproval of a CME program.

Hospital Surveyed May 23

The recommendation for one-year provisional accreditation was made by a survey team which visited the hospital on May 23 and conducted interviews with key personnel and physicians. This recommendation was accepted by a Review Sub-Committee of the Committee on Medical Education and Hospitals and, in turn, was approved by the full Committee at its meeting on June 17.

Members of the survey team and the Review Committee were appointed by Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals. The Review Committee was set up on a permanent basis to accept reports from future survey teams and make recommendations to the full Committee.

Members of the survey team were Dr. William E. Gilmore of Parkersburg, Chairman; Dr. Mary Lou Lewis of Charleston, and Dr. Richard G. Starr of Beckley (as a local observer).

Serving on the Review Committee are Dr. Richard V. Lynch, Jr., of Morgantown, Chairman; Dr. George M. Kellas of Wheeling; and Drs. Gilmore, Lewis and Starr.

Physicians Accompany Team

Accompanying the survey team to Beckley were Dr. Rutledge W. Howard, Associate Director, Department of Continuing Education, AMA; Dr. Ross L. Egger, Daleville, Indiana, a member of the AMA's Advisory Committee on Continuing Medical Education, and Custer B. Holliday, Executive Assistant, State Medical Association. Drs. Howard and Egger, because of their experience in CME surveys, were in a position to provide valuable assistance and guidance as the State Medical Association initiated its first survey.

Formal approval of the Beckley hospital's accreditation is expected by the AMA's Advisory Council on CME and the Council on Medical Education at their next regular meetings in the fall.

CME accreditation is voluntary in nature and must be requested by the hospital. It is anticipated that the new state accreditation service will strengthen CME, at the same time making accredited programs more accessible to physicians at the local level.

State One Of 11 With Program

West Virginia was among the first five states to apply for the AMA-approved accreditation program and now is one of 11 states with the program in effect. The other states are Arizona, California, Connecticut, Illinois, Indiana, Maryland, New Jersey, New Mexico, Pennsylvania, and Tennessee.

The state plan includes provisions for accreditation of community hospitals; state, county and city hospitals; local specialty or other medical societies, local voluntary health organizations, and other organizations or institutions which sponsor CME programs. Initial efforts, however, will center about community hospitals.

Institutions interested in being surveyed for CME accreditation may obtain additional information by writing: Committee on Medical Education and Hospitals, West Virginia State Medical Association, P. O. Box 1031, Charleston, West Virginia 25324.

Painless Removal of Decayed Teeth

A chemical called GK-101 may soon remove the fear and possibly the discomfort of visiting the dentist, according to a recent report of the National Society for Medical Research. GK-101 is sprayed on the decayed area where it dissolves the darkened areas painlessly without harm to the surrounding healthy tooth material.

74 WVU Graduates Beginning Internships, Residencies

Scheduled to begin internships or residencies July 1 were the 67 men and seven women who were graduated May 20 from West Virginia University School of Medicine.

Results of the National Intern and Matching Program, the computerized system that pairs senior medical students and hospitals according to the choices of both, show that more than one-third of the 74 WVU-educated new physicians will remain in West Virginia for their internship or first year of residency.

Other states that attracted the graduates include: Ohio (8), California (7), Florida (6), Pennsylvania (5), Virginia (4), Tennessee (3), Wisconsin, Colorado and North Carolina (2 each), and District of Columbia, Texas, Illinois, Minnesota, Maryland, Connecticut, Massachusetts, South Carolina, Missouri and Utah (1 each).

Types of internships and residencies chosen and the number of graduates in each are: Medicine (26), Rotating (23), Surgery (8), Obstetrics and Gynecology (6), Psychiatry (4), Pediatrics and Family Practice (2 each), and Anesthesiology, Dermatology and Pathology (1 each).

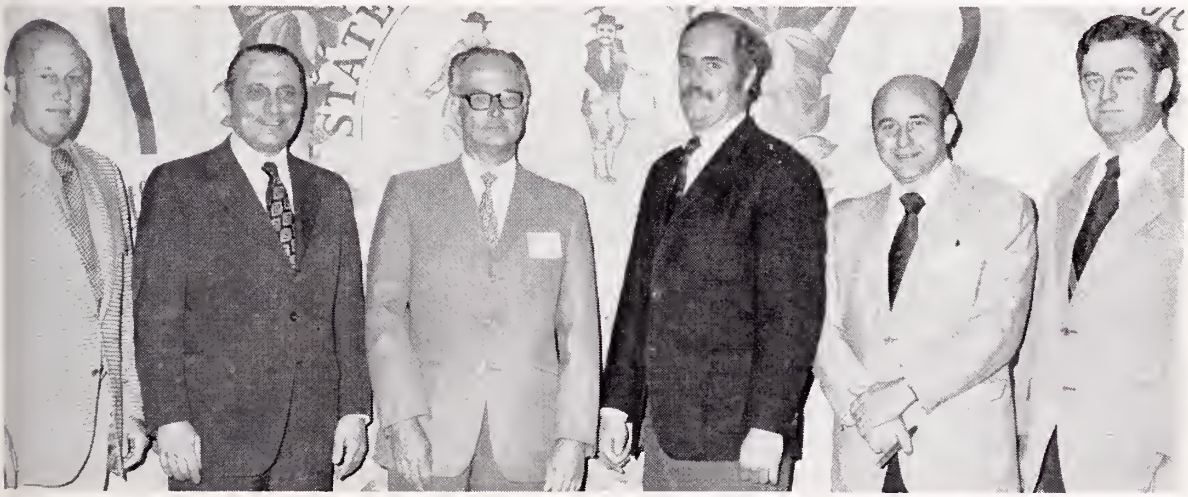
Alphabetically, the graduates, their home towns and the hospitals where they will take additional training, are:

Malcolm M. Alt, Petersburg, Tampa General Hospital; Edward F. Arnett, Rowlesburg, Harrisburg (Pa.) Polyclinic Hospital; John L. Benedum, Bridgeport, Akron City Hospital; Kenneth M. Brock, Fairmont, Charles F. Kettering Memorial Hospital, Kettering, Ohio; B. Thomas Brown, Summersville, WVU Hospital Department of Surgery; Charles W. Buffington, Wheeling, WVU Hospital Department of Anesthesiology; Larry A. Caserta, Barboursville, Charleston Area Medical Center (CAMC), Memorial Division; Michael R. Cashdollar, Chester, Geisinger Medical Center, Danville, Pa.; Shawn A. Chillag, Holden, CAMC, Memorial Division.

Patrick J. Condry, Morgantown, WVU Hospital Department of Medicine; Lewis A. Cook, Beckley, Riverside Hospital, Newport News, Va.; Emmett Cox, Charleston, WVU Hospital Department of Pediatrics; Jan H. Cunningham, New Martinsville, Akron City Hospital; Leon J. Davis, Coraopolis, Pa., U. S. Naval Aviation Medical Center, Pensacola, Fla.; William A. Davis II, Mullens, Georgetown University Hospital, Washington, D. C.; Rodney D. Dean, Huntington, CAMC, Memorial Division; Stephanie Deverick, Charleston, Bayfront Medical Center, St. Petersburg, Fla.; Barbara F. Durning, Annandale, Va., WVU Hospital Department of Psychiatry; Robert P. Durning, Milmont Park, Pa., WVU Hospital Department of Medicine.

David R. Finch, Parkersburg, University Hospitals, Madison, Wisc.; David C. Fogarty, Pittsburgh, Stanford University School of Medicine, Palo Alto, Calif.; John W. Gilmore, Vienna, Presbyterian Medical Center, Denver; Richard D. Glock, S. Charleston, University Hospital of Jacksonville, Fla.; William T. Harless, West Columbia, S. C., Mercy Hospital and Medical Center, San Diego; Homer P. Hatten, Huntington, Cincinnati General Hospital; John R. Hitt, Richwood, CAMC, Memorial Division; Robert L. Hively, Dunbar, CAMC, Memorial Division; Vera L. Hoylman, Gassaway, CAMC, Memorial Division; Thomas C. Jones, Clarksburg, Baroness Erlanger Hospital, Chattanooga.

William P. Joseph, Wheeling, Highland General Hospital, Oakland, Calif.; Thomas S. Kickler, Belle Vernon, Pa., University Hospitals, Madison, Wisc.; Ann M. Kinzer (Clark), Charleston, WVU Hospital Department of Obstetrics and Gynecology; Emerson L. Knight, Penryn, Pa., Harrisburg (Pa.) Polyclinic Hospital; Gregory B. Knowlton, Sistersville, William



New officers recently were elected at a meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier. Shown above, from left, are Dr. William Lawton, Second Vice-President, Charleston; Mr. John Pompelli, Department of Organization, ACS; Dr. Charles Hershey, Governor, Wheeling; Dr. James Thomas, President, Bluefield; Dr. Angelo Daniel, First Vice-President, Wheeling; and Dr. Alvin L. Watne, Secretary-Treasurer, Morgantown. The next scheduled meeting will be in Morgantown, November 16 and 17.

Shands Teaching Hospital and Clinics, University of Florida, Gainesville; James L. Kwako, Bismarck, N. D., CAMC, Memorial Division; John C. Lambert, Wayne, Presbyterian Medical Center, Denver; John E. Lenahan, Bellerose, N. Y., Santa Clara Valley Medical Center, San Jose, Calif.; Stephen I. Lester, Huntington, WVU Hospital Department of Surgery; Danny M. Linkous, Holden, Baylor College of Medicine Affiliated Hospitals, Houston.

James E. Loyd, S. Charleston, and William D. Martin, Weirton, Vanderbilt University Hospital, Nashville; Deborah J. McCloud, Mt. Clare, Great Lakes (Ill.) Naval Hospital; David C. McClure, Morgantown, WVU Hospital Department of Medicine; Brittain McJunkin, Charleston, University of Virginia School of Medicine, Charlottesville; Stephen K. Milroy, Richwood, Roanoke Memorial Hospitals; David T. Murray, Spencer, University Hospital of Jacksonville, Fla.; David M. Nally, New Martinsville, WVU Hospital Department of Surgery; Kathleen A. O'Farrell, White Sulphur Springs, St. Paul-Ramsey Hospital, St. Paul, Minn.; Evan S. Pokorney, Wheeling, Presbyterian-University Hospital, Pittsburgh.

Thomas A. Reeder, Morgantown, WVU Hospital Department of Medicine; Bill B. Richmond Jr., Beckley, Naval Hospital, Bethesda, Md.; Russell A. Salton, Williamson, Charlotte (N. C.) Memorial Hospital; Jerome M. Schnitt, Huntington, University of Connecticut Affiliated Hospitals, Hartford; Ivan R. Schwab, Kingwood, Santa Clara Valley Medical Center, San Jose, Calif.; William J. Sembello, Martinsburg, Harrisburg (Pa.) Polyclinic Hospital; Joseph E. Shaver, Lewisburg, Community Hospital of Roanoke (Va.) Valley; Wilbur Z. Sine, Hundred, WVU Hospital Department of Psychiatry; John G. Stansbury, S. Charleston, Charlotte (N. C.) Memorial Hospital.

Ralph A. Stevens, Huntington, University of Cincinnati; James A. Stewart, Mayfield Heights, Ohio, St. Vincent Hospital, Worcester, Mass.; Thomas L. Stover, New Manchester, Akron City Hospital; Stanard L. Swihart, Fairmont, WVU Hospital Department of Obstetrics and Gynecology; Sally H. Swisher, New Creek, WVU Hospital Department of Medicine; Richard F. Terry, Wheeling, Akron General Hospital; Joel R. Thompson, Mullens, Akron City Hospital; Peter K. Thrush, Clarksburg, WVU Hospital Department of Psychiatry.

John A. Wade, Charleston, CAMC, Memorial Division; Bruce A. Wapen, Springfield, Pa., Kaiser Foundation, San Francisco; Edward A. Waybright, Williamstown, Medical University of South Carolina, Charleston; Joseph W. Werthammer, Huntington, University Hospital of San Diego (Calif.) County; Rodney R. Williams, White Sulphur Springs, CAMC, Memorial Division; Donald A. Withrow, St. Albans, Jewish Hospital of St. Louis, Mo.; Jackson J. Woods, Shinnston, Latter Day Saints Hospital, Salt Lake City; Joseph D. Wright, Charleston, CAMC, Memorial Division.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

July 16-19—Ruidoso (N.M.) Summer Clinic (N.M. Chap., AAFP, Spon.).

July 28-Aug. 2—Natl. Med. & Dental Assn. of Am., French Lick, Ind.

July 30-Aug. 3—Am. Acad. of Clin. Toxicology, San Diego.

Aug. 17—Medic Alert Found., Turlock, Calif.

Aug. 19-20—Am. Acad. Med. Administrators, Chicago.

Aug. 20-23—Am. Health Congress, Chicago.

Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Aug. 28-31—Wyo. St. Med. Soc., Jackson Lake Lodge.

Sept. 6-8—Am. Assn. Ob. & Gyn., Hot Springs, Va.

Sept. 14-15—W. Va. Heart Assn., Charleston.

Sept. 16-20—Am. Assn. of Med. Clinics, L. A.

Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.

Sept. 17-20—Ky. Medical, Louisville.

Sept. 17-21—Am. Acad. of Oph. and Otol., Dallas.

Sept. 19-23—Pa. Med. Society, Phila.

Sept. 20-23—Am. Soc. Internal Med., Dallas.

Sept. 27-29—Natl. Conf. Cancer of Colon & Rectum, Bal Harbour, Fla.

Sept. 29-30—AMA on Alcoholism, Pocono Manor, Pa.

Oct. 1-4—AAFP, Denver.

Oct. 6-11—Indiana St. Med. Assn., Indianapolis.

Oct. 7-11—Am. Soc. Anesth., San Francisco.

Oct. 10-13—Pa. Med. Society (Scientific), Harrisburg.

Oct. 15-19—ACS Clinical, Chicago.

Oct. 17-21—Eastern Orthopaedic Assn., White Sulphur Sprgs.

Oct. 18-21—Med. Soc. of Va., Norfolk.

Oct. 18-21—Amer. Acad. of Child Psych., Washington.

Oct. 20-25—Amer. Acad. of Ped., Chicago.

Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.

Oct. 21-26—Am. Acad. Physical Med. & Rehab., Washington.

Oct. 22-24—Am. Coll. of Gastro., L. A.

Oct. 26-28—Pot.-Shen. PG Institute, Martinsburg.

Oct. 31—Nov. 1—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 4-9—Am. Public Health Assn., San Francisco.

Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.

Nov. 8-12—Am. Assn. Cancer Educat., Honolulu.

Nov. 8-13—Am. Heart Assn., Atlantic City.

Nov. 12-15—Sou. Medical Assn., San Antonio.

Nov. 14-17—Am. Acad. of Neuro. Surgery, Pasadena.

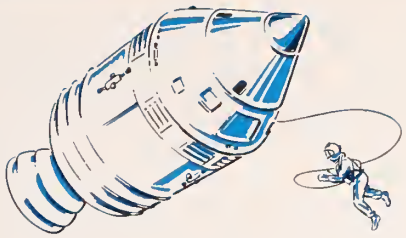
Dec. 1-6—Am. Acad. of Derm. Chicago.

Dec. 1-5—AMA Clinical, Anaheim, Calif.

1974

Jan. 18-20—Mid-Winter Clinical Conf., Charleston.

Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.



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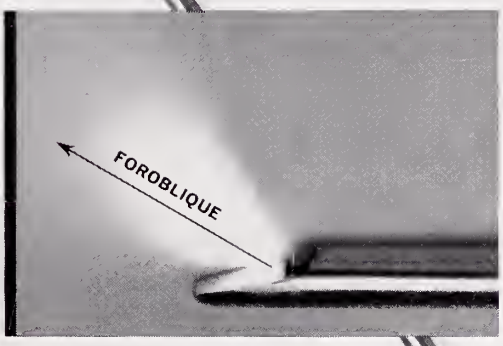

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WVU Medical Center
–News–

• Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

DR. Barbara Jones, Professor and Assistant Chairman of the Department of Pediatrics at West Virginia University School of Medicine, has been selected for active membership in the American Pediatric Society, a prestigious 580-member organization of academic pediatricians.

Two others from the department belong to the group, Dr. W. G. Klingberg, Professor and Chairman, and Dr. Edwin R. Hughes, Professor.

A member of the faculty since 1961, Doctor Jones is well known for her work with young patients who have cancer, particularly leukemia. She is chairman of the West Virginia Chapter of the American Academy of Pediatrics.

17 Physicians Begin Internships

Seventeen physicians and two dentists were to begin internships July 1 at West Virginia University Hospital. As WVU graduates, 12 in the group will gain the new experience in a familiar setting.

By service, the newcomers to the hospital's house staff and the schools from which they graduated are:

Rotating Anesthesia—Dr. Charles W. Buffington, WVU;

Rotating Dental—Dr. David Funderburk, WVU;

Straight Medicine—Dr. Patrick J. Condry, Dr. Robert P. Durning and Dr. David C. McClure, WVU; Dr. John E. Mateer, Milton S. Hershey Medical Center (Penn State); Dr. Robert J. Olson, University of Minnesota; Dr. Thomas A. Reeder, WVU; Dr. Ronald Richardson, University of Minnesota; Dr. Sally H. Swisher, WVU;

Rotating Pediatrics—Dr. Emmett Cox, WVU;

Straight Pediatrics—Dr. Cynthia Battiste, Northwestern University; Dr. Stephen P. Herman, Milton S. Hershey Medical Center; Dr. Samuel Kocoshis, Medical College of Wisconsin;

Oral Surgery—Dr. Greg J. Wrobleski, WVU;

Straight Surgery—Dr. B. Thomas Brown and Dr. Stephen I. Lester, WVU; Dr. R. Scott Liebl, Medical College of Wisconsin, Dr. David M. Nally, WVU.

Before presenting the annual Alpha Omega Alpha Lecture recently at West Virginia University School of Medicine, Dr. Leonard D. Fenninger (right) talked with the honor medical society's president, new member from the faculty, and new members chosen in their junior year. They are (from left, standing) Russell A. Salton, II of Williamson, President; Dr. W. Keith C. Morgan, Professor of Medicine; Robert D. Stewart of Dunbar; (from left, seated) Ronald C. Hill of Parkersburg, Charles T. Adkins of Pineville, Larry B. Wilshire of Chelyan, Thomas G. Kenamond of Wheeling, and William N. Cunningham of Charleston. Doctor Fenninger is Associate Director for Health Manpower, National Institutes of Health. WVU medical students elected to AOA last fall, as seniors, were Patrick Condry of Morgantown, William P. Joseph of Wheeling, Emerson L. Knight of Penryn, Pennsylvania; Brittain McJunkin of Charleston, David M. Nally of New Martinsville, William J. Sembello of Martinsburg, and Peter K. Thrush of Clarksburg.

General and Thoracic Surgery
Stephen T. J. Lee, M. D.
James A. Gardner, M. D.

Orthopedics
Clifford A. Stevensan, M. D.
S. A. Zahir, M. D.
Mario C. Ramas, M. D.

Obstetrics-Gynecology
Charles W. Merritt, M. D.
Warren D. Elliatt, M. D.
Owen C. Meadaws, M. D.
Rabert P. Pulliam, M. D.
T. J. Ma-Luf, M. D.

Ophthalmology
Edward T. Liu, M. D.

Urology
S. L. Francis, M. D.

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Jase L. Oyca, M. D.
Eugene Warvariv, M. D.
R. James Yates, M. D.

Pediatrics
P. B. Gogo, M. D.
R. G. D. Cancepcian, M. D.

Ear, Nose & Throat
P. C. Corra, M. D.

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The Month in Washington

• From the Washington Office of the American Medical Association.

STRONG protests from the American Medical Association and others has led the Secretary of the Department of Health, Education, and Welfare to hold letters from Social Security's Bureau of Health Insurance that ordered Medicare and Medicaid intermediaries to augment hospital utilization review by requiring a pre-admission certification program, and the use of national, regional or other appropriate data on length of stay by diagnosis to establish extended-stay cut-off dates.

In letters and visits with HEW Secretary Caspar W. Weinberger, AMA Board Chairman, John R. Kernodle, M. D., urged that " . . . The Social Security directive be reviewed, not only from the standpoint of its validity under the Medicare law, but also with respect to its apparent preemption of functions given by the Congress to Professional Standards Review Organizations (PSRO).

" . . . We believe the purpose of an intermediary letter should be limited to administrative matters affecting carriers. If providers of service are affected we believe that any changes should be the subject of proposed regulations under which the providers and the carriers are given an opportunity to present their views. In the case of the intermediary letters under consideration, we question their validity and appropriateness at this time. We believe that they should not be issued at this time and that they would more appropriately be included in the PSRO regulations."

Social Security stated that the proposed new instructions in its intermediary letters "are intended to be supportive of the PSRO effort."

The reason for the new procedures, according to Social Security, is "increasing public concern at all levels over the need for more effective utilization of health care while maintaining or improving the quality of care rendered."

Social Security describes the new instructions as "processes that are to be employed for the period prior to the emergence of PSROs. Hospitals will require that the attending physician present appropriate documentation for use by the UR committee, or its representative, for approval of the hospital admission prior to—or at the time of—elective admissions, and within one working day subsequent to emergency or urgent admissions.

"A representative of the utilization review committee will review all applications for admissions of Medicare beneficiaries; however, not all would be reviewed in the same depth. By employing a selection technique found appropriate by SSA, the utilization review committee will subject an appropriate number of the applications for admission to close, professional scrutiny. For example, the utilization review committee will be required to review intensively all questionable admissions (i.e., those involving questionable diagnosis, and treatments, for which close review is appropriate because of high cost, frequency of abuse, or propensity for potential misutilization.")

"All admissions approved by the utilization review committee will be certified by the committee for a specific duration based on appropriate percentile of past data (or other data acceptable to the Secretary). Where the committee does not approve the admission, the attending physician and the beneficiary is to be notified immediately, i.e., within 24 hours. Reviews of admissions are to be scheduled prior to or at the time of the expiration of the initial projected length-of-stay and in subsequent additional stays where the attending physician recommends and the utilization review committee approves continuing hospitalization. Appeal rights are to be provided to protect the beneficiary, hospital, and the attending physician from improper denials.

"The proposed new procedure calls not only for a change in timing of review but for analysis of utilization review findings and the correction of problems that are identified . . . "

Social Security said the intermediaries would conduct on-site reviews to "verify that pre-admission certifications and subsequent reviews are made timely and conscientiously." Carriers would be required to exchange information to identify "potentially aberrant patterns of service and to take appropriate corrective action."

Physicians Take Case To Washington

Some 150 physicians representing 38 state medical associations and foundations have visited congressmen and federal officials to make a case that statewide PSRO coordinating systems should be permitted when the program is implemented.

The government has indicated that statewide PSROs are likely in only very small states though the law contains no such restriction. Chief congressional sponsor of PSRO, Sen. Wallace Bennett (R., Utah,) insists the intent of the law is to bar statewide setups in larger states.

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Robert E. O'Connor, M.D.
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Nancy McClung, M.S.

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Catherine Kenney, CRNA
Inez Maggio, CRNA
Muriel Dodds, CRNA

Obituaries

RALPH HOMER BOICE, M. D.

Dr. Ralph Homer Boice, of Parkersburg, died on May 7 at his home there after a long illness. He was 89. Doctor Boice was a Past President of the Parkersburg Academy of Medicine and the Radiological Society of West Virginia.

He opened the first x-ray laboratory in Parkersburg at St. Joseph's Hospital in 1927 and at the Camden-Clark Memorial Hospital a short time later.

A native of Gallipolis, Ohio, Doctor Boice was a graduate of the Ohio State University Medical School. He served his internship at St. Luke's Hospital in Philadelphia and a residency in radiology at Mercy Hospital in Pittsburgh. He did postgraduate work at Memorial Hospital in New York City and at Heinz Hospital in Chicago.

Doctor Boice was a veteran of both world wars.

He was a member of the West Virginia State Medical Association, the American Medical Association, the Radiological Society of North America and the American Academy of Radiology. He was a Diplomat of the American Board of Radiology and a Fellow of the American College of Radiology.

Survivors include the widow; one stepson, W. D. McGrew, Jr., of Atlanta, Georgia, and four grandchildren.

* * * *

CECIL A. JARRELL, M. D.

Dr. Cecil A. Jarrell, of South Charleston, died on May 11 at his home. He was 56.

Doctor Jarrell was on the staffs of St. Francis and Charleston General Hospitals in Charleston, and Thomas Memorial Hospital in South Charleston. He was plant physician for FMC Corporation at South Charleston for 13 years.

Doctor Jarrell was a graduate of Tulane Medical School in New Orleans.

Survivors include the widow; two daughters, Mrs. A. J. Zanon of Rome, New York and Mrs. J. E. Rectenwald of South Charleston; two sons, John H. Jarrell and James A. Jarrell of Morgantown; the mother, Mrs. L. F. Jarrell of Comfort; three sisters, Mrs. Marie Eddy of Vienna, Mrs. Martha Foster of Charleston, and Mrs. Mary Jo Mosser of Fort Lauderdale, Florida; two brothers, Judge Donald E. Jarrell of Danville and Dr. Carl B. Jarrell of Charleston, and four grandchildren.

* * * *

THOMAS H. McGAVACK, M. D.

Dr. Thomas H. McGavack, retired Associate Chief of Staff of the Veterans Administration Center in Martinsburg, died in that city on May 23. He was 75.

Since his retirement in 1969, Doctor McGavack had served as consultant at the hospital. A native of Waterford, Virginia, he received his A. B. degree in 1917 from Hampden-Sydney College and his M.D. degree in 1923 from Hahnemann Medical College in Philadelphia.

Doctor McGavack took his internship at Hahnemann Hospital, then remained as a resident in pathology. His career included wide experience as lecturer in medicine at George Washington University, visiting physician, professor of clinical medicine, and consultant in endocrinology and metabolism in hospitals in New York, New Jersey and California, prior to coming to the VA Center at Martinsburg in 1961.

Doctor McGavack was a Past President of the American Geriatrics Society. He was a Fellow of the New York Academy of Sciences, the New York Academy of Medicine, the Harvey Cushing Society, the Endocrine Society, and the American College of Physicians.

He was the author of a number of books and more than 300 articles in medical journals.

A member of the Governor's Commission on Aging and the Governor's Advisory Committee on Health, he was active in programs for senior citizens in Berkeley County.

Doctor McGavack was a member of the Eastern Panhandle Medical Society, the West Virginia State Medical Association, the American Diabetes Association, and the American Thyroid Association. He was a life member of the American Association for Advancement of Science.

He is survived by one daughter, Mrs. Lloyd Durant of Santa Barbara, California; two brothers, Louis McGavack of Waterford and John McGavack of Leonia, New Jersey; and four grandchildren.

* * * *

ANDREW JAMES NIEHAUS, M. D.

Dr. Andrew James Niehaus, practicing physician in Wheeling for 35 years, died there on May 7. He was 64.

Doctor Niehaus was a Past President and Treasurer of the Ohio County Medical Society.

A native of Mannington, Doctor Niehaus completed his academic work at West Virginia University and received his B. S. degree in medicine there in 1931. He received his M. D. degree in 1933 from the Rush Medical College in Chicago.

Doctor Niehaus was associated with the emergency room at the Ohio Valley General Hospital from 1964 until 1972. Upon his retirement from the hospital he joined the Wheeling Clinic Service.

He was a member of the Ohio Valley Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Survivors include the widow; four daughters, Mrs. Carole Ryder of Boseman, Montana; Mrs. Susan Lewis of Charleston, and Mrs. Andrea Allen and Miss Jenny Niehaus of Wheeling; one brother, Jack Niehaus of Wheeling; one sister, Miss Grace Niehaus of Wheeling, and seven grandchildren.

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OBITUARIES—(Continued)

ALBERT CECIL VAN REENEN, M. D.

Dr. Albert Cecil Van Reenen of Bluefield, died on May 12 at St. Luke's Hospital there after a long illness. He was 76. Doctor Van Reenen served 37 years on the staff of St. Luke's as the anesthesiologist, retiring in 1972.

A native of Marlinton, Doctor Van Reenen received his B. S. Degree in Medicine in 1922 from West Virginia University and his M. D. degree in 1924 from the Medical College of Virginia. He did graduate work at Children's Hospital in Chicago and at George Washington University.

Doctor Van Reenen was a member and Past President of the Mercer County Medical Society, and also was a member of the West Virginia State Medical Association, the American Medical Association, and the American Society of Anesthesiologists.

Survivors include the widow; two sons, Rev. Albert C. Van Reenen, Jr., of Clendenin, and Lawrence Cornelius Van Reenen of Birmingham, Alabama; five brothers, Gilbert, of Marlinton; Porter, of Baltimore, Maryland; Forrest, of Warren, Ohio; Hubert, of Beard (Pocahontas County), and Carl, of Beckley; and four sisters, Mrs. Ella Tyler and Mrs. Margaret Barlow, of Marlinton, Mrs. Jane Dilley, of Warren, Ohio, and Mrs. Myrtle Frampton, of Huntington.

County Societies

CABELL

The Cabell County Medical Society met on May 10 in Huntington. The Ad Hoc Committee to evaluate PSRO legislation recommended participation in a Foundation program with the West Virginia State Medical Society rather than a tri-state organization. An explanatory letter and ballot were to be mailed to each member of the County Society.

Dr. Roy A. Edwards, Jr., a member of the State House of Delegates from Cabell County, gave an interesting review of the recently adjourned Legislature.

Dr. Gene Herdt presented an enlightening talk on arteriography.

Dr. Thomas F. Scott, President, asked for volunteers to participate in a training program for the Community Service Officers of the Huntington Police Department, Emergency Medical Care. This training program will be primarily concerned with resuscitation and cardiac problems.—Charles H. McKown, Jr., M. D., Secretary.

* * * *

MERCER

Dr. Worthy W. McKinney, President of the State Medical Association, spoke at the meeting of the

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E. C. Voss, M. D.

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W. F. Park, M. D.
M. E. Nugent, M. D.
R. V. Pangilinan, M. D.

Ear, Nose & Throat:
W. A. Tiu, M. D.

Orthopedic Surgery:
E. L. Borrett, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
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Robert T. Brandfoss, M. D.
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Dermatology:
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A. K. Butler, M. D.
J. N. Aceto, M. D.

Speech Pathologist and Audiologist:
James P. Frum, M. S.

Clinical Laboratories:
Donna Burlenski
Donna Bryan

Technologists:
Electrocardiography:
Betty Maguire, R. N.
Brenda Muklewicz, R. N.
Electroencephalagraphy:
Joann Green, R. N.
Juanita Stone, R. N.
Raentgenalagy:
Evelyn Farester, R. T.

Administration:
Lester L. Cline, Manager
Henry L. Castilow, Asst. Mgr.

Mercer County Medical Society on May 21 in Princeton at the Dinner Bell Restaurant.

Doctor McKinney discussed informally the changes in medical practice since years ago and the changes that are coming. He urged physicians to resist government regimentation and control.

Dr. Hawey A. Wells, Jr. proposed a toast to Dr. Frank J. Holroyd, of Princeton, for his recent successful operation.

A minute of silent prayer was observed in the memory of Dr. A. C. Van Reenen, of Bluefield, who died on May 12.

Announcement was made of the infirmary dedication at Camp Joy, on Sunday, June 24, as a memorial to Dr. Robert Gatherum.

Drs. Mariano T. Cabral and Richard W. McGan were unanimously elected to membership.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

The Monongalia County Medical Society held a joint meeting with the State Dental Association and the State Bar Association on May 1 at the Old Mill Club in Morgantown.

The speaker for the evening was Mr. F. M. Taylor, of Charleston, representing the Aetna Life and Casualty Company. He discussed the State Medical Association's Professional Liability Program.

Approved by the Society were motions that payment for medical fees be expanded in the coverage by the state insurance package, the State Welfare Department, and for Federal employees. A letter was to be written to the State Insurance Commission and the Blue Cross-Blue Shield Commission handling the state insurance package requesting that medical fees be made the equivalent of surgical fees. Another letter was to be written to the State Welfare Department suggesting a "fee for service" in addition to being paid for any office services such as laboratory fees and injections.—H. Summers Harrison, M. D., Secretary.

* * * *

OHIO

The Ohio County Medical Society sponsored a one-day athletic injury and sports medicine clinic on May 24 in Wheeling at Oglebay Park's Wilson Lodge.

The speakers included Dr. J. R. Ramsey, Team Physician at Dartmouth University; Dr. Winston P. Riehl, Director of Student Health Services at Tulane University and a physician with the 1972 U. S. Olympic team; Allen W. Hart, Head Athletic Trainer at Ohio State University;

Dr. Joseph C. Maroon, Assistant Professor of Neuro-Surgery at the University of Pittsburgh and Consultant to the university's athletic teams; and Dr. K. Douglas Bowers, Jr., Team Physician at West Virginia University.

Attending were area team physicians, coaches, trainers and other interested parties.

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HANCOCK

Dr. Myer Bogarad, who has practiced medicine in Weirton for 43 years, was presented honorary life memberships in the West Virginia State Medical Association and the Hancock County Medical Society on May 15. Doctor Bogarad was honored at a dinner meeting held by the Society at the Williams Country Club.

The county membership was presented by Dr. Dominic A. Brancazio, President of the Hancock Medical Society, while the state membership tribute was presented by Dr. Worthy W. McKinney, President of the West Virginia State Medical Association. Doctor McKinney also addressed the members of the Society.

In attendance were Mrs. Bogarad and their three sons, Irwin M. Bogarad, also a Weirton physician; Martin Bogarad, a Weirton attorney, and Allen Bogarad, Dean of the University of New York.

Doctor Bogarad was the first President of the medical and dental staffs of Weirton General Hospital. He is the oldest practicing physician in point of service in Hancock and Brooke counties, and was honored several years ago as West Virginia's "Doctor of the Year."

Doctor Bogarad is a Past President of the Hancock Medical Society and the West Virginia Chapter, AAFP (1959-60). He is a member of the Committee on Aging of the State Medical Association. He received his medical degree in 1928 from St. Louis University School of Medicine and began the practice of medicine in Weirton the following year.

The Bogarads and Doctor McKinney were honored after the meeting at an informal reception held in the home of Dr. and Mrs. Ray S. Greco of Weirton.

It was stated in an editorial of tribute by the Weirton Daily Times that, "There's no finer medical practitioner, from the standpoint of capability, dedication and personality, than Dr. Myer Bogarad."

TYGART'S VALLEY

The 24th Annual Post Graduate Session of the Tygart's Valley Medical Society was held on June 21 in Grafton at Tygart Lake Lodge.

Guest speakers at the afternoon session were Worthy W. McKinney, M. D., President of the West Virginia State Medical Association; and Paul E. Nora, M. D., Ph.D., Chairman of the Department of Surgery at Columbus-Cuneo Medical Center, Chicago; and Assistant Professor of Surgery at Northwestern University, Chicago. Doctor Nora spoke on "Contemporary Biliary Surgery."

Guest speaker for the evening banquet session was Dr. Richard E. Shearer, President of Alderson-Broaddus College at Philippi, whose subject was "Myths About the Private Sector."

The guests were welcomed and introduced by S. M. Santibanez, M. D., President of the Tygart's Valley Medical Society.

A golf tournament was held during the morning at the Tygart Lake Country Club.

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PG Course On Infectious Diseases

An American College of Physicians Postgraduate course, "Diagnosis and Management of Infectious Diseases," will be held September 12-14 at Howard University College of Medicine in Washington, D. C.

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Some consideration will be given to common parasitologic conditions seen in this country.

The fee for ACP members will be $100; nonmembers, $150. Registration forms and requests for information are to be directed to Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

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T. H. Chang, M. D.

Gynecology and Obstetrics:
Raymond W. Cronlund, M. D.

Internal Medicine:
E. G. Guy, M. D.
B. G. Thimmappa, M. D.
Karl J. Myers, Jr., M. D.

Pediatrics:
D. F. Manger, M. D.
E. G. Kreider, M. D.

Anesthesiology:
G. E. Hartle, M. D.

Dentistry:
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Broaddus Hospital Resident Staff:
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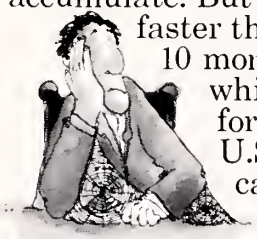

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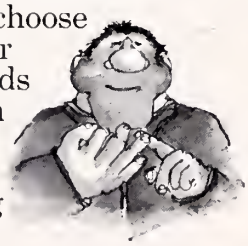

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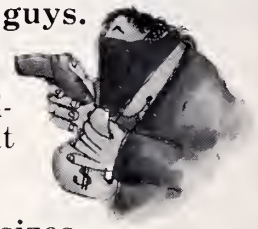

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EMERGENCY ROOM PHYSICIAN — Accredited 280-bed progressive general hospital in beautiful Huntington, West Virginia; excellent income and working conditions; send resume to Assistant Administrator, Cabell Huntington Hospital, 1340 Sixteenth Street, Huntington, West Virginia 25701.

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GENERAL SURGEON WANTED—Must have necessary qualities for advancement to Chief of Staff or Medical Director. Salary open. Medium size hospital in Southern West Virginia. Fully accredited with modern furniture and equipment. Contact CAW, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

NOTICE—Grafton City Hospital is pleased to announce its affiliation with Alderson-Broaddus College as a primary institution for the training of physicians assistants and nurses. Needed to augment the medical staff are a general practitioner, internist and an obstetrician-gynecologist. New hospital will be completed within three months and the training program will start in September 1973. Salary and subsidies can be arranged. Contact Wallace B. Murphy, M.D., Chief of Staff, Grafton City Hospital, Grafton, West Virginia 26354.

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Precautions: In the elderly and debilitate and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing grac ally as needed and tolerated. Not recommended in children under six. Though generally not rec ommended, if combination therapy with other psychotropics seems indicated, carefully conside individual pharmacologic effects, particularly ir use of potentiating drugs such as MAO inhibit and phenothiazines. Observe usual precautions presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulati and acute rage) have been reported in psychiatr patients and hyperactive aggressive children. Employ usual precautions in treatment of anxie states with evidence of impending depression; suicidal tendencies may be present and protecti measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been establish clinically.

Adverse Reactions: Drowsiness, ataxia ar confusion may occur, especially in the elderly an debilitated. These are reversible in most instanc by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In few instances syncope has been reported. Also er countered are isolated instances of skin eruption edema, minor menstrual irregularities, nausea a constipation, extrapyramidal symptoms, increas and decreased libido—all infrequent and general controlled with dosage reduction; changes in EE patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, ma ing periodic blood counts and liver function test advisable during protracted therapy.

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the West Virginia Medical Journal

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AUGUST 1973

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and a few may need counseling
and the psychotropic action of Valium® (diazepam).

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ent is presently taking drugs
if so, what his response has
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you determine initial dosage,
possibility of side effects and
ultimate prospects of success
ilure.

While Valium can be a most
ful adjunct to your counseling,
ould be prescribed only as long
xcessive psychic tension per-
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followed, Valium is well
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e been the most commonly re-
ted side effects.

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nplete mental alertness, such
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Before prescribing, please consult complete product information, a summary of which follows:

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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AUGUST
1973

Vol. 69 No. 8

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

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2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia.* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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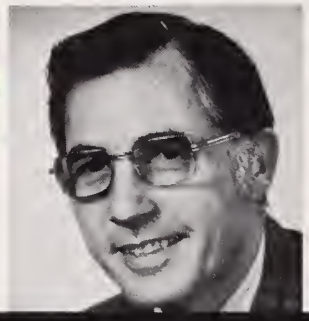
Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indi ent to the economic consequenc their decisions." So stated a rece issue of *Medical News Report* (D cember 4, 1972), an independe weekly newsletter published by f AMA Chief Executive F. J. L. Blas game, M.D.

Doctor, are you indifferent...?

In discussing an anticipate crease in Blue Shield rates, Dr. E ingame's newsletter had this to s

"In general, it can be said, I have given the impression they a not particularly concerned with t increase in cost of health care to patients...

"True, an MD's training is p marily scientific, but in the real v of practice, all of his scientific de sions have a price tag, or an ecor impact. The economics of health beckon the practitioner's attenti Concern for economics of medic

When the pharmacist recor mends that a drug product other a the one ordered be dispensed, th prescriber invariably permits the change when he feels the best in ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is n sary for the prescriber to know th the change is being contemplate and to be in a position to consent demur. Without that opportunity, unilateral decision of the pharma made in the absence of clinical kn edge of the patient, could expose to needless risks, and in addition, jeopardize the relationship betwe the professions of Pharmacy and Medicine. In my view, there is not in the pro-substitution argument a offsets these risks.

The Issue of Drug Knowledge

Substitution advocates clair that the primary justification for changing the rules is the desire to better utilize pharmacists' knowle about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some deg puts him at a disadvantage. Most often, a practicing physician will ed expert knowledge of no more than 5

Advertisement

l be an obligation of medical
ce...

Medical societies ought to con-
ontinuing campaigns to point
e substantial savings that could
lized thru deductible insurance
otection for catastrophic ill-
At the very least, they should, in
tients' interest, question the
s of any insurance organization
ises health care costs by forc-
licyholders to buy insurance
nay not need or want and prob-
von't ever use.

"Too many doctors are indifferent
the economic consequences of
decisions. Too many, for ex-
e, habitually hospitalize patients
e convenience of the MD. It's
ense to deny such habits exist...

"Doctors, thru their medical so-
s, have unhesitatingly appealed
ir patients for support in the
against government interference
he private practice of medicine.
he public in the past has re-
ded. It's time the American Med-
Association and state and local
cal societies paid off the debt by
ive action to hold down the cost
edical care."

of Drugs

Insurance rates and hospital
ges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

) drugs that he selects to treat the
rity of conditions encountered in
ractice. Moreover, the physi-
's choice of a specific brand is
d on his knowledge of the pa-
t's medical history and current
dition, and his experiences with
particular manufacturer's
duct.

Some substitution proponents
e argued that the dispensing of a
scription is a simple two-party
saction between the pharmacist
the patient, and that a substitut-
pharmacist may avoid even a
nical breach of contract by simply
fying the patient that he is making
substitution. I would judge that
courts would be sympathetic
ard a pharmacist who substituted
hout physician approval and who
ertook a legal defense that seeks
nake the patient responsible for
pharmacist's actions.

uced Prescription Prices?

Substitution advocates are
gesting to the consumer, and par-
larly the consumer activist, that
uced prescription prices could
w legalization of substitution.
have seen absolutely no evidence
stify this claim. To the contrary,
erience in Alberta, Canada, where
stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

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The West Virginia Medical Journal

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Preserve This House of Medicine*

Charles A. (Carl) Hoffman, M. D.

As I take leave of the presidency, let me reiterate the views with which I started my term:

The essential relationship in medicine is between physician and patient. Delivery of care is that relationship *multiplied.* This conviction has been my guiding star throughout my year at the helm. May it be a lodestar for all of us through the years ahead. It is a belief that is easily stated — but this does not mean that it is easily followed or sustained. Indeed, there is a real and present danger that the delivery of care actually will conflict with the doctor-patient relationship. Let me explain.

The bond between doctor and patient is inseparable from the *quality of care.* For quality encompasses human as well as clinical skills . . . an ability to minister to the fears of the patient and his family as well as to his sickness . . . an ability to see him as an individual and — beyond that — as a "whole person."

On the other hand, many of the current proposals for delivery of health care emphasize *quantity* of available services . . . the mass of people served rather than individuals. Their proponents fancy that quality can be extended automatically. They fail to understand its individual basis . . . in the way that they understand the social and statistical basis of quantity.

Our House of Medicine . . . our Association . . . was created for the pursuit of *quality.* Our achievement of it inscrolls our record and our reputation. This pursuit — this achievement — is the primary reason for our strength and our survival. Quality must always be the heart of whatever we do to broaden the delivery of care.

The Author

- **Charles A. (Carl) Hoffman, M. D., Huntington, West Virginia; Immediate Past President of the American Medical Association.**

Broaden it we must. But unless delivery to the public has that heart, we shall fail that public.

Much of my year in office has been a quest for ways to reconcile the delivery of care with the quality of care. I decided at the outset that leadership called for learning and questioning —

Charles A. (Carl) Hoffman, M. D.

*Presidential Address delivered by Doctor Hoffman at the First Session of the AMA House of Delegates in New York City, June 24, 1973.

rather than for assuming that I already had all the answers. My quest took me across the country and across the ocean. I visited — as I said I would — the health-care systems of Britain, Sweden, West Germany and Russia, and the misguided system on our U. S. Indian reservations.

In my travels, I found much that was good and much that was regrettable. Still, whatever I encountered was helpful to me in formulating my views — the ideas which I have proposed over the year — and those which I want to share with you now.

Common Premise and Common Purpose

These proposals have a common premise and a common purpose — they each seek to uphold and ensure the quality of medical care — and to rule out any action that would undermine it.

Let me begin by stating that the quality of medical practice can be no better than the education on which it is founded. A paradox has arisen, however. At the same time that we have insisted on continuing education for the physician in practice, we have condoned a reduced curriculum for the student in medical school.

Continuing education is designed to safeguard the quality of medical practice. Reduced curricula, in my judgment, constitute a threat to quality of care. I recognize that this Association has backed certain experiments and measures to reduce the time spent by students in medical schools. But now I must ask the question — "Why?"

"Why?"— when the sheer volume of knowledge to be absorbed is greater than ever before.

"Why?"—when the true need of our profession is to produce — not narrowly trained super-specialists — but human physicians who understand and relate to people.

"Why?"— when the most important single quality in a physician is maturity of judgment. Maturity is a quality that develops out of time and experience. It can hardly develop within the context of a speedup.

"Why?"

I have asked that question all year. I have not heard an answer that responds to the points I have just raised. But I think I know one reason why — and so do each of you. It was — in part, at least — a response to the hue and cry over the so-called physician shortage. But was it a wise response? Is it consistent with quality medical care? Is it in the best interests of the nation? Will it even still the hue and cry?

The answer to all those questions is "no."

The truth is that we *never* will have enough physicians to meet the demand. We *can* meet the *need* — and we are well on our way to doing so. But satisfying the *demand* for physician services will forever elude us.

This demand we can never meet — for it is based upon unreasonable expectations. And we must educate the American people to *that* fact — while at the same time we take every step to ensure the availability of high quality medical care to meet the legitimate needs of every American.

Sound Educational Programs

And let it begin with sound educational programs in our medical schools. Sound education means — first — that the curriculum should be designed to give the student the amount of knowledge he needs for the role he will play. It does not mean a curriculum engineered to produce a certain number of M.D. degrees within a certain period of time.

Sound education means — second — a broad rather than a narrow education. We in medicine are becoming more aware of the need to treat the "whole person"— no matter what our specialty. Who can treat the "whole person" but a "whole physician"? This requires more courses — not fewer — in the humanities and the arts. The telescoped curriculum which emphasizes the sciences at the sacrifice of the liberal arts is a disservice to both the student physician and to his future patients.

Certainly, we need physicians who are first-class scientists if we are to ensure quality care. But just as important — we need physicians who are also first-class *humanists.*

And—third—if we are to produce "whole physicians"— then the abolition of the rotating internship is a mistake. I believe most strongly that it should be revived — for it gives the future specialist a first-hand opportunity to learn of the many facets of medicine.

And to further broaden the experience it affords, I believe the internship should be served strictly in community hospitals. Teaching hospitals would then concentrate on specialized training. I believe it is far more important to meet the needs of our patients through sound education programs than to attempt to meet the hue and cry of the various self-annointed spokesmen for our patients.

A Dangerous Hoax

The physician shortage alleged by these spokesmen is a dangerous hoax.

It is dangerous because it misstates the problem — misleads the people — and creates false hopes.

It is a hoax because it implies that if we hurry up and produce the magic number of physicians, the problem of access will be resolved.

It is a hoax because our national ratio of 133 direct-care physicians per 100,000 population is already one of the highest in the world — and keeps improving each year.

Numbers are not the problem . . . and never have been. And numbers are not the solution . . . and never will be.

Maldistribution of Physicians

The problem is distribution — or more precisely — maldistribution. Maldistribution of physicians is not a problem unique to the United States. It is a worldwide problem. No nation has solved it. If I learned nothing else in my travels and discussions this year, I certainly learned that.

What I did learn was that attempts to insure universal access are most often self-defeating. I had this point brought home to me in England by one of the architects of Britain's National Health Service. He told me that, in the early 1960's, he set about trying to eliminate the waiting period that patients in England face in non-emergency cases. But after some study and experimentation, he gave up the idea.

For, he told me, he had discovered a basic truth — that when rendering a service to the public, you must have one of two safeguards against abuse — either a monetary control or a waiting period. Without either of these mechanisms, the system — *any* system — will be plagued by abuse and will not provide the service intended. Britain has learned that lesson, and Canada is learning it.

Possible Answers to Maldistribution

Is there an answer to maldistribution? The only answer, I believe, lies in programs directed specifically at that problem. One of these is the National Health Service Corps, which has done such a good job of placing federal physicians and allied professionals in medically deprived communities.

This program could be broadened, I believe, if the federal government or state or both would underwrite the education of needy young medical students. In return, they would agree — by contract — to serve a period of time in medically deprived areas upon completion of their education.

This arrangement would enable the students to pay off their debts and lay a financial groundwork for private practice. No student should be — or would be — compelled to make such a commitment. But once the contract was signed, he would be bound by it. I would offer the same opportunity to current medical students or recent graduates as a means of erasing their debts.

Hopefully, some of the young physicians would elect to remain in an area once their period of service was completed. But at a minimum the program could assure continuity of service — if not continuity of physicians.

Maintenance of Quality

Such a program has one further advantage. It ensures the maintenance of quality — by maintaining the physician as the central force in the delivery of health care in the areas served. And that is important. For I see a tendency — a dangerous tendency, in my judgment — to resort to second-line personnel — particularly physicians' assistants — as the remedy for underserved areas.

We of the AMA endorse larger roles and broader responsibilities for nurses and other allied personnel . . . provided the duties are well defined and the physician's authority is maintained. The role of physicians' assistants must be clearly defined and its limitations clearly understood. Properly placed and properly employed, they can play an effective role in doing what their name implies — assisting the physician. But they must be content with that role.

In any event, we must oppose absolutely any attempt to make physicians' assistants physician substitutes. And we must reject completely any program that would cast them in that role. We must — in good faith — oppose *any* concept or any program that would undermine — or even threaten to undermine — the quality of medical care.

Dangers of Kennedy-Griffiths Bill

And this — in my judgment — is the primary danger of the Kennedy-Griffiths bill.

All the familiar arguments against the bill — its impact on the national treasury and on income tax rates, and its elaborate bureaucracy — are all valid concerns and reason enough to reject it. But those are all economic concerns. Its most

insidious threat is to the quality of medical care in this country. Why does it constitute a threat to quality of care? There are two reasons. One is inherent in the nature of government — and the other in the nature of man.

The first . . . and lesser . . . of these I observed first-hand in both the English health care system and in our own government Indian Health service. What has happened in both systems is eventually true of every government program; the financial support proves inadequate.

So what happens when the money runs out?

A general medical officer in the Indian Health Service in Oklahoma summed up the dilemma in this way:

"As a physician, I'm being forced into situations that require me either to deliver poor medical care — or to spend money against orders and warnings from the government bureaucracy. The result is poor medical care and frustration for both patients and physicians."

This is one danger deriving from the nature of government. The second — deriving from human nature itself — is more profound.

Loss of Motivation

The real cost of the Kennedy-Griffiths bill is the price that would be paid in human motivation. And loss of motivation ultimately has an adverse effect on quality. It cannot be otherwise. This — I am convinced — is implicit in *any* nationalized system — whether it be health care or any other service. And make no mistake about it — that is what we are resisting: nationalization of health care.

Not socialized medicine — nationalized medicine.

For years we have talked about the specter of socialized medicine. Well, friends, if that's the battle we're fighting, we can stop. The battle's over. We've already lost.

We have socialized medicine in this country — and we've had it for years. We have it in the form of Medicare and Medicaid. We have it in the 38 per cent of our citizens covered by government programs. We have it in the millions of employees covered by union programs — with the premiums paid by employers. If you think any of these approaches is contrary to socialized medicine, look it up in the dictionary.

The true danger and the true objective of the Kennedy-Griffiths bill is nationalized health care — the complete and total takeover of the entire health care delivery system by the government.

Does this mean that we should stand opposed to any kind of government involvement in health care? The obvious answer to that is "NO."

We support — and should support — certain specific government activities in health care, such as manpower training, research, construction and education grants. Our objection is not to government per se — but to the improper intrusion of government into health care delivery.

The Indian Health Service

One thing I believe we should urge the government to do is meet the responsibilities it has already assumed. I refer, in particular, to the Indian Health Service. I have already noted the impact that a shortage of funds can and does have on the quality of Indian care. There is an additional problem when an Indian goes off the reservation.

On the reservation — from my observations — the primary health care is generally good. If some of the hospitals I saw were transferred to an inner city area, we'd be boasting about them. But the situation changes when an Indian leaves the reservation. Then he runs into discrimination — a discrimination based largely on his lack of money.

Both of these problems, I believe, could be readily resolved if the government simply provided for all Indians the same type of health insurance coverage it now provides for its employees — in this case, the government would pay the entire premium. Equipped with a card, an Indian then could apply for the necessary health care on the reservation or off.

Improving Emergency Medical Care

A second action the government could undertake would help no single group . . . but all groups. The government should adopt the AMA Emergency Medical Care legislation. Such action would provide the necessary funds for a major effort to improve emergency medical care in this country.

No other act by government would have so dramatic or so direct an impact on the actual quality of care. In 1970, Americans made some 43 million visits to the emergency facilities of community hospitals. That's one for every five citizens. I witnessed at first hand in Leningrad, Russia how effective a well-organized emergency care system can be. And we have some excellent models in our own country.

Our AMA Council on Emergency Medical Care has done much to upgrade the qualifications and skills of ancillary personnel in ambu-

lances and emergency rooms. But their efforts can go only as far as their resources allow. How much more could be done — with adequate resources.

Proper Role of The Government

This is the proper role of government in health care: supportive — not intrusive.

Our task and our responsibility are to properly define — and to limit — government's role. As with power, the most important single thing to learn about government is its limitations — to know where it should stop — to recognize what it can and can't do. Unfortunately, it is a lesson that we as a people too often learn the hard way.

Most of all, our responsibility is to ensure that government does not intrude on the physician-patient relationship — and that its actions do *not* impair the quality of care. That is why I am in favor of our taking a strong leadership role in developing and implementing PSRO.

In my judgment, the concept of PSRO was implicit in the passage of Medicare and Medicaid. I was opposed to Medicare for three reasons. First, universal eligibility is a misuse of government funds. Second, there were bound to be abuses by a minority, for which the majority would pay — so that third, controls would be sure to follow.

Well, it passed and the controls are here. Unless we are going to tilt with windmills and fight the battle of Medicare all over again, we are going to have to learn to live with controls. I do not like controls. I do not know anyone who does. And the opposition of this Association to PSRO *before* its enactment was clearly established.

Leadership Role in PSRO

It is now the law of the land. There is still some question in my mind whether it will work. But clearly the government intends to attempt to make it work. Perhaps — with our cooperation — PSRO can be made an effective law. Without our involvement, I have little doubt that it would become an oppressive law — and a real intrusion on medical care.

We should be alert . . . and see that the physician's rights are respected at each step in the road. Let us proceed to seek a responsible partnership with government on PSRO. But let it be with this understanding: that while government can have our cooperation, it can never have our surrender.

To prevent the improper intrusion of government into medicine, we must have a strong political arm. We really have very little choice in the matter — that necessity has been forced upon us — like it or not.

But the real danger is that we *will* like it — too much. There is a subtle and seductive quality about politics that can easily entrap the unwary. It is so easy to fall into the trap — to begin playing the game for its own sake — and to forget why one got into the game in the first place.

Basic Objectives Defined

The only protection against such seduction is to keep our objective clearly defined and clearly in mind. What should our basic objective be?

It should be the same one that our Association set out with when it was founded 126 years ago. Very simply — to improve the quality of health care. Let *that* be our goal and our standard of judgment . . . and we will never go astray.

Physician-Patient Relationship

Even more, let it be our enduring commitment — let us communicate that commitment to the public — and we shall have nothing to fear for our profession in the future. That commitment and that communication must begin in each of our offices. For *that* is where the public relations for our profession truly begins — in the relationship between each of us and each patient.

We often talk about that relationship. I wonder sometimes, though, just how much any of us really think about it. And if we really comprehend just how very important it is to us.

I had the message brought home to me in Sweden. My fellow urologist there told me that the loss of the individual patient-to-physician relationship was the greatest defect of the Swedish system. He told me that whatever we do to change our system — we should maintain that relationship as the basis of the practice of medicine.

Opposition to Unionism

I consider it to be our greatest strength as a profession. And I am opposed to doing anything that would weaken or destroy it. It is mainly for that reason that I am opposed to our profession turning to unionism as the answer to our problems.

Our sense of unity as a profession derives from *serving* the public — not from holding it as a hostage. The latter course is an inevitable result of unionism. No matter how noble the intentions at the outset, it cannot be avoided — for unions possess no other strength.

The ultimate cost of that course in terms of public ill-will and government intervention would most surely outweigh any short term gain. It is not narrow self-interest but rather our commitment to quality medicine that should be the tie that binds us together — and the tie that binds us to the public.

Can we preserve the doctor-patient relationship?

I had that question asked of me by a 30-year-old physician in Albuquerque. My answer was this: "You'll see it when you are 80 — if you are willing to work." I firmly believe that work *is* the basic ingredient of medicine — and of the AMA.

Throughout the year, I have tried to represent the doctor-patient relationship between the House of Medicine and the American people. Like the presidents before me, I have tried to leave this Association a better place than I found it. And I believe that progress has been made.

Based on my experience this year, I believe the AMA is far more popular with the public than its critics would have you believe. And if my visits with diverse groups of people across the land — and sometimes around the clock — had anything to do with that, I am grateful.

Wonderful Cooperation and Goodwill

In whatever I have done and wherever I have traveled, I received wonderful cooperation from the AMA staff and friendliness from the media — and for that I am grateful. I always invited criticism from reporters and interviewers — and I am pleased to report that while they were often forthright, they were never abrasive.

As your constant ambassador, I sought goodwill — and I received it. My term has passed quickly. However, I see it not as an isolated year — but as part of the countless years ahead for this House of Medicine.

This House will always be strong — provided the bonds of that strength are its bonds with patients, singly and collectively. It will always be vital — if it can keep its windows open to fresh ideas on the delivery of care — while maintaining the quality of care as its foundation.

To every physician who wonders what future is in store for medicine, I will say at the end of this year as I said at the beginning: *Preserve this House of Medicine — for only it can preserve your future.*

Trans-Sphenoidal Surgery For Pituitary Lesions

William M. Chadduck, M. D.; and G. Robert Nugent, M. D.

CLASSICALLY, pituitary tumors have made themselves known by the clinical features of acromegaly produced by acidophilic adenomas, Cushing's disease produced by the rare basophilic adenomas and, most commonly, by evidence both of endocrine and optic system abnormalities caused by chromophobe adenomas of the pituitary. Any mass lesion occurring in the region of the pituitary fossa can encroach upon the optic chiasm and optic nerves producing defects both in the visual fields, (usually a bitemporal hemianopsia) and in the visual acuity. Hypopituitarism also can be seen with many other lesions in the region of the sella turcica including craniopharyngiomas, pituitary cysts and other less common disorders. The efficacy of radiotherapy in the treatment of pituitary tumors has been noted frequently, especially with chromophobe adenomas, but is admittedly less effective in the treatment of acidophilic adenomas and craniopharyngiomas. Moreover, the variety of disease processes occurring in the region of the sella turcica makes a tissue diagnosis virtually mandatory prior to any consideration of radiotherapy.

Hardy[1] has been responsible for significant refinements in the trans-sphenoidal approach to the pituitary region. Using the operating microscope and radiofluoroscopic monitoring, the sella can be visited relatively easily, with very little morbidity as compared with approaches requiring craniotomy and brain retraction.

In the past, major involvement of the visual system has been an indication for surgical treatment, and whereas many patients are improved following surgery, their vision rarely returns to normal. In addition, the patients are almost always left without any pituitary function following such surgery, rendering them dependent upon life-long replacement therapy.

It seems appropriate, then, that when such lesions are suspected, trans-sphenoidal removal of the lesion should be accomplished before significant involvement of the visual system occurs. In many instances, normal or almost normal pituitary function can be preserved. The trans-sphenoidal approach can be used also for hypophysectomy in treatment of endocrine dependent neoplasms such as carcinoma of the breast or prostate.

This communication briefly describes the surgical technique and reports case histories indicating the usefulness of the procedure, the necessity of establishing a tissue diagnosis, and the feasibility of early treatment of pituitary tumors.

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Surgical Technique

Under general endotracheal anesthesia, the patient is placed in the supine position for the operation. Portable fluoroscopic equipment with image intensification is positioned to monitor the approach through the sphenoid into the sella turcica. The nose, mouth and hypopharynx are prepared and appropriately draped. The mucous membranes at the upper gum, the base of the nose over the hard palate and the nasal septum are infiltrated with xylocaine and epinephrine.

A transverse incision is made above the upper gingival margin and by means of a submucosal dissection, exposure is accomplished posteriorly through the nasal cavity with submucous resection of the nasal septum. Part of the vomer is cracked allowing exposure of the sphenoid sinus which is entered and its ostium enlarged. The mucous membrane of the sphenoid sinus is pushed laterally to either side, exposing the anterior wall of the sella turcica. A specially designed self-retaining nasal speculum is then utilized to maintain exposure. A large opening is then made in the anterior wall of the sella turcica using x-ray control and microsurgical technique. The dura overlying either the tumor or the pituitary gland can then be opened, and with microdissection gland or tumor can be removed or biopsied. In the case of an acidophilic adenoma it may be possible to remove the adenoma without destroying the remainder of the pituitary gland. In cases of chromophobe adenoma, partial removal may be accomplished in smaller tumors which then can be subsequently radiated. If the patient already has abnormal pituitary function, the entire tumor may be removed, but the patient will require subsequent hormonal replacement. A piece of fat or fascia obtained from the thigh is placed into the empty sella which is then sealed, using a piece of the cartilage obtained from the nasal septum. Packs are then placed in the nasal cavity to reposition the mucous mem-

branes and the incision in the gingiva is closed with several absorbable sutures. In cases in which the anterior wall of the sella turcica has been destroyed by tumor, an acrylic plate can be utilized to close the sphenoid sinus. Spinal drainage occasionally is used postoperatively, but blood replacement is rarely necessary.

Clinical Reports

SB (WVU 146923), a 29-year-old female had been evaluated at West Virginia University Hospital because of chronic headaches. Radiographs of her skull had shown a sella turcica which was considered to be at the upper limits of normal. Because of this finding, she had subsequent x-rays made (Figure 1) which showed progressive enlargement of the sella turcica. The patient and her family were well aware of the possibility that she had a pituitary tumor inasmuch as she had been followed with neurologic examinations, visual field examinations, endocrine studies and repeated x-rays for several years. Endocrine evaluations for pituitary functions were all within normal limits, and visual acuity and visual field testing also showed no abnormalities. The patient had normal menstrual periods, an indication of relatively intact pituitary function. Angiography essentially ruled out the presence of an aneurysm and pneumography showed neither an empty sella nor extrasellar extension of the lesion.

The patient underwent elective trans-sphenoidal exploration of the pituitary fossa and a chromophobe adenoma was found. The tumor was not an isolated adenoma as is usually seen with the acidophilic tumors in acromegalics but appeared to diffusely involve the gland. Total surgical removal would have been exceptionally easy with this case; postoperative panhypopituitarism, however, would have been unavoidable. Therefore, having established the diagnosis, the patient underwent radiotherapy. Following her treatment, she still has normal pituitary function, normal menstrual periods, and no defects in the visual fields. She has no evident surgical scar and is hopefully cured of her disease process. The classical management of waiting for the tumor to produce either hypopituitarism or visual system dysfunction therefore seems questionable.

RS (WVU 266976), a 40-year-old man was referred because of an enlarged sella. The patient had been evaluated for headaches and sinus trouble associated with a deviated nasal septum. He had noticed some increased fatigability but was referred only because sinus x-rays demonstrated, incidentally, an enlarged sella turcica.

His examination showed a sallow skin color, absence of hair in the axillary regions, and pseudomyotonic tendon reflexes consistent with hypothyroidism. His laboratory studies were consistent with panhypopituitarism, but the visual system examination was completely normal. X-rays of the skull (Figure 2) showed marked enlargement of the sella turcica. Radiographic contrast studies again were helpful in excluding aneurysm, the empty sella syndrome and extrasellar extension.

The patient was thought definitely to have a pituitary chromophobe adenoma; at the time of trans-sphenoidal exploration, however, he had a large pituitary cyst which was decompressed. Multiple biopsies showed no evidence of neoplasm, and therefore radiotherapy was not indicated postoperatively. The patient showed some degree of psychomotor retardation postoperatively, this being a transient and unexplained phenomenon. As expected, he improved with hormonal replacement therapy.

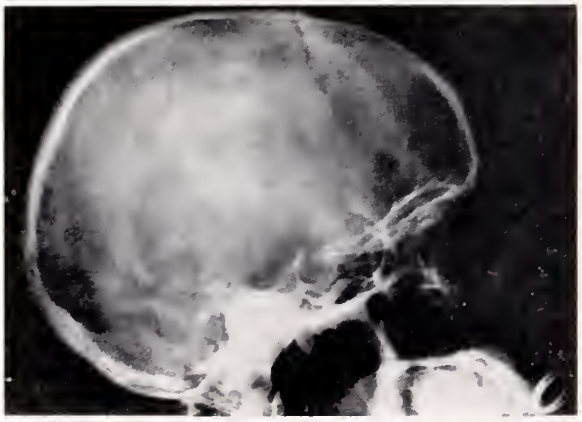

Figure 1. Lateral view of the radiograph of the skull of patient S.B. shows a large ballooned sella. The patient had an asymptomatic chromophobe adenoma.

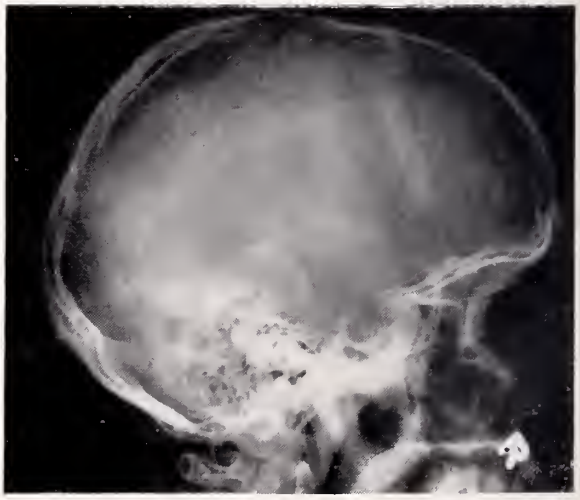

Figure 2. Lateral view of the x-ray of the skull of patient R.S. shows a markedly enlarged sella turcica. The patient had subnormal pituitary function and was thought to have a pituitary chromophobe adenoma. At operation the lesion proved to be a pituitary cyst.

SG (WVU 251336), a 21-year-old girl was referred for evaluation of pituitary tumor. The symptoms which first brought her to a physician were two or three periods of amenorrhea lasting four to five months each. Radiographs of the skull showed an enlarged sella turcica but formal neuroendocrinologic evaluations were normal as were examinations of the visual system. A third nerve palsy developed due to lateral extension of her pituitary tumor into the cavernous sinus, and only then was radiotherapy considered. Since the patient had familial polyposis, the possibility of a metastatic lesion to the pituitary also was considered.

She underwent trans-sphenoidal biopsy and partial removal of her rather extensive tumor proved to be chromophobe adenoma, and she subsequently received a curative dose or radiotherapy. She has had some improvement in the third nerve palsy but defects in visual fields or visual acuity have never developed. Earlier treatment surely would have spared involvement of the oculomotor system. She has preservation of endocrine function as evidenced by her laboratory studies as well as her resumption of normal menstrual periods.

OB (DMH 392402), a 64-year-old female was admitted to Memorial Hospital, Danville, Virginia, because of recurrent metastatic carcinoma of the breast. She had numerous scalp nodules as well as cutaneous metastatic deposits. Her chest x-ray showed additional pulmonic infiltrates, and laboratory studies indicated increased alkaline phosphatase activity and increased urinary calcium excretion.

The patient underwent trans-sphenoidal hypophysectomy following which she had an immediate response to the ablative therapy based on clinical evaluation and laboratory data. Before leaving the hospital five days postoperatively, her scalp and subcutaneous nodules had decreased to approximately one-half of the preoperative size and when the patient was seen six months later there were no palpable nodules. The appearance of the chest x-ray did not change remarkably, but the patient was able to return to work as a full-time teacher for another year.

Discussion

The four cases reported demonstrate the value of trans-sphenoidal surgery of the pituitary region in decreasing the morbidity when pituitary surgery is called for by classic operative criteria. It is relatively easy to work within the confines of the sella without resorting to craniotomy, frontal lobe retraction, or dissection around the optic nerves, optic chiasm and hypothalamus. Thus far, fifteen cases have been operated using this approach. In none has there developed cerebrospinal fluid rhinorrhea, infection, or optic nerve trauma. One patient with a metastatic tumor to the pituitary required blood transfusion. One patient had an unexplained, but fortunately transient, confusional state. None of the patients had a surgical scar on the face or head, and in one instance, a patient's preoperative nasal deformity was incidentally improved.

In addition, these cases demonstrate the need for and efficacy of trans-sphenoidal biopsy of pituitary lesions in diagnosing the various disease processes. At times the results are surprising. The differential diagnosis of sellar lesions has become extensive as a result of more accurate diagnostic facilities. The patient who has an enlarged sella turcica and panhypopituitarism cannot be assumed to have a chromophobe adenoma. Various other possibilities include metastatic tumor, aneurysm, leptomeningeal cyst, arachnoid cyst, epithelial cyst, empty sella syndrome, myoblastoma, choriocarcinoma, sphenoid sinus mucocele, intrasellar chordoma, craniopharyngioma, and meningioma, to mention a few[2].

Finally, the ability to explore and surgically treat lesions in the sella and at the same time preserve normal pituitary function is demonstrated. Two of the patients have normal pituitary function postoperatively and require no endocrine replacement therapy. The ability to microdissect tumor from gland either for biopsy purposes or for total removal, as in the case of acromegalics, must be considered a significant surgical advance, and gives impetus to the concept of early diagnosis and treatment of pituitary tumors. It no longer seems preferable to await involvement of the visual system before considering treatment. Radiotherapy for undiagnosed lesions of the pituitary rarely seems justified. Further, as shown by Becker and Vries[3] acidophilic tumors should be treated surgically initially, as normal glandular function can be preserved in most cases, whereas dissection of the tumor from an irradiated gland often is impossible and frequently is followed by panhypopituitarism.

Summary

Refinements in the trans-sphenoidal surgical approach to the sella turcica, using fluoroscopic monitoring and microsurgical techniques, have markedly decreased the morbidity of pituitary surgery. Often normal glandular function can be preserved. Early diagnosis and treatment of pituitary lesions should be considered.

A list of references may be obtained by writing The Journal.

Special Article

Geographical Patterns Of Infant Mortality In West Virginia

Robert Davis, M. A.; and Mary Ellen Mazey, M. A.

In recent years, the United States has experienced an overall reduction in infant mortality. Since infant mortality rates often have been regarded as the most sensitive index of the general level of socio-economic well-being that characterizes a population, one can assume that as a whole, the United States is improving socio-economically and medically.[1] All of the states, however, have not shared equally in this progress. In the 1960s, West Virginia was in the low per capita income group of states and also had a higher than average rate of infant mortality. The purpose of this study is to investigate West Virginia's contemporary situation in detail and to demonstrate geographical patterns. Also, the United States in 1970 had an average infant mortality rate of 19.8 per 1,000 live births, while West Virginia's rate of 23.3 was above average.[2,3]

Numerous studies have been done relating infant mortality with socio-economic factors. These studies were in agreement upon their findings. The studies concerned with Boston, Massachusetts; Hartford, Connecticut; and Providence, Rhode Island found that the majority of infant deaths occur within the first month of life, and these are not associated with socio-economic conditions, but probably are due to biological factors. In contrast, the deaths that occur between one month and one year were found to be associated with socio-economic status in all three cities. At this stage in life, the biological factors are less influential than the social and environmental ones. It was found that after the first month, the leading causes of death were primarily infectious, such as bronchitis, pneumonia and diarrhea; other causes were accidental ones such as suffocation or poisoning.[4,5,6] Similar findings were noticed in a report using data from the National Natality and National Infant Mortality Surveys of 1964-1966. This survey which covered the entire United States found that the highest infant mortality rates were in the lowest socio-economic groups after the first week of life.[7]

It has been found that states with lower income levels have a higher infant mortality rate. When states were grouped into high, middle and low per capita income levels, it was found that those in the low per capita income grouping (17 states) had a 19 per cent higher rate of infant mortality than the national average. Also, in this group of low per capita income states, six per cent of the births were physician unattended compared with the four-tenths per cent for the middle per capita income group. West Virginia and several other Appalachian states were in this low per capita income grouping.[8]

There seems to be a consensus from these studies that low socio-economic factors, although important in themselves, do not directly determine high infant mortality. Other variables such as size of family, illegitimate births, status and age of mother have been shown to be associated with infant mortality as well. It seems that infant mortality is related to a complex pattern of high birth rates, infant care and poor living conditions.[9] One of the purposes of this paper is to see how West Virginia's infant mortality rates and socio-economic status compare with other studies using these same variables.

The definition of infant mortality as used in this study can be divided into three parts. First, total infant deaths which includes infant deaths under one year from all causes, but excludes fetal deaths. Second, neonatal deaths, which includes all deaths in which the infant is born alive, but dies within the first month of life. Third, post-neonatal deaths which includes deaths from one month to one year.

Infant mortality in West Virginia was examined at a county level using 1970 data. The findings were only partially in agreement with

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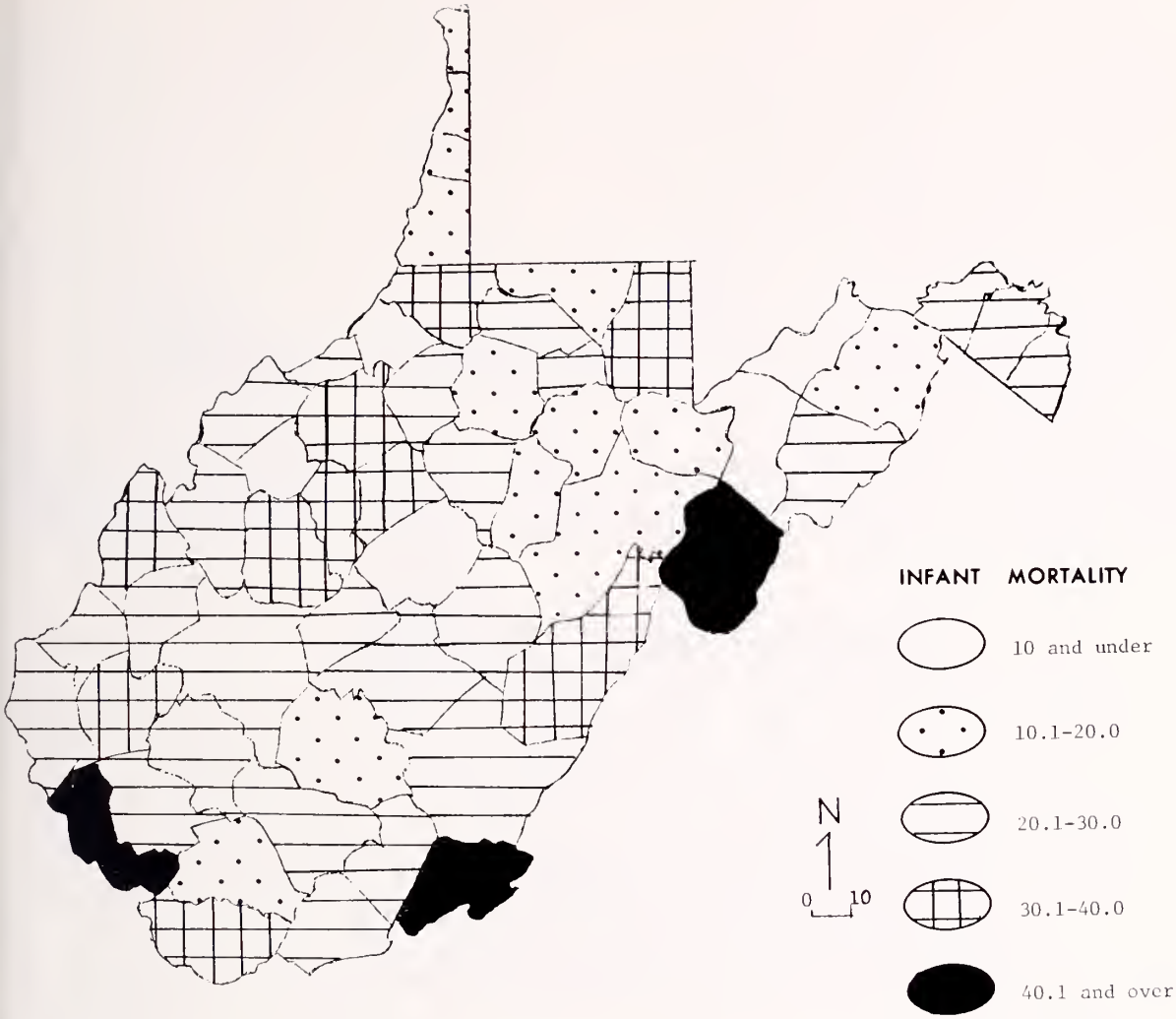

previous studies. Correlation analysis used to test the relationships found that there was no "significant" statistical relationship between socio-economic status and neonatal mortality in West Virginia. As stated earlier, previous studies had found relationships with postneonatal mortality and socio-economic status but no "significant" relationship was found between these variables in West Virginia. A multiple correlation coefficient value of .221 would have been significant at the .05 level. The correlation coefficient between neonatal mortality and the socio-economic variables (such as education, income, employment), however, was .07. The correlation coefficient between postneonatal mortality and the socio-economic variables was only .04.

To better analyze infant mortality in West Virginia, the spatial distribution is shown on the outline county map (see map). This map showing the 1970 distribution of infant mortality in West Virginia demonstrates some interesting characteristics (Data are taken from *Vital Statistics — 1970* published by the West Virginia State Department of Health).

The five categories on the map show the rates of total infant mortality per 1,000 live births. Since the United States average of infant mortality in 1970 was 19.8, it is interesting to note that over two-thirds of West Virginia's counties had a higher rate than this national average in 1970. According to the map, the northern panhandle, one of the major industrial areas of the state, had relatively low infant mortality rates, while the rural counties — Monroe, Mingo and Pendleton — had extremely high rates. Other counties that had rather high rates (30.1 to 40.0 per 1,000) were Wetzel, Preston, Ritchie, Gilmer, Calhoun, Roane, Mason, Lincoln, Pocahontas, and McDowell. To further analyze this situation, one must consider that the majority of these counties with high rates of infant mortality are predominantly rural, and therefore it could be concluded that health services are not as accessible to the people in these counties as com-

pared with the more urban counties such as Hancock, Marshall and Ohio.

In conclusion, the West Virginia map of infant mortality suggests that other variables and conditions must certainly be understood in order to better explain the apparent unique distribution of infant mortality rates in West Virginia. It is hoped that this report calls to attention once again, the fact that medical care as well as other related variables are widely geographically dispersed in West Virginia. Also, future medical and socio-economic policies in West Virginia might want to be directed towards those areas in West Virginia which clearly demonstrate the greatest need.

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A list of references may be obtained by writing The Journal.

To Physicians in Training

To all physicians in training and especially West Virginia residents. West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal. The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual immediate attention.

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He has Trichomonas vaginalis?

It's his infection but her problem...

Men with trichomonal infection are virtually always asymptomatic, which is why they seldom know they have the disease. But many do have it, nevertheless.

Trichomonal infection is so common that estimates[1] indicate one out of every four women of reproductive age has the disease. *Almost half of the husbands of women infected with* Trichomonas vaginalis *have it, too.*[2-9]

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Indications: For the treatment of trichomoniasis in both male and female patients and in the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. The oral tablets are indicated also for acute intestinal amebiasis (amebic dysentery) and amebic liver abscess.

Contraindications: Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in ECG tracings.

Dosage and Administration: For Trichomoniasis. *In the female:* One 250-mg. tablet orally three times daily for ten days. Course may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high

e vaginal vault each day for ten days and
ral dosage is reduced to two 250-mg. tab-
daily during the ten-day course of treat-
..Do not use the vaginal inserts as the sole
of therapy. *In the male:* Prescribe Flagyl
when trichomonads are demonstrated in
urogenital tract, one 250-mg. tablet two
s daily for ten days. Flagyl should be taken
oth partners over the same ten-day period
n it is prescribed for the male in conjunc-
with the treatment of his female partner.

Amebiasis. *Adults:* For acute intestinal
biasis, 750 mg. orally three times daily
to 10 days. For amebic liver abscess, 500
50 mg. orally three times daily for 5 to 10
s. *Children:* 35 to 50 mg./kg. of body
ht/24 hours, divided into three doses,
y for ten days.

age forms: Oral tablets 250 mg.
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References:

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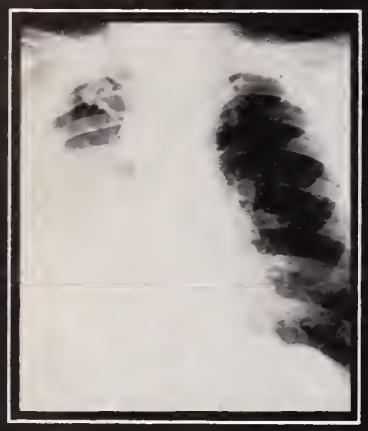

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106th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 22-25, 1973

PLAN NOW TO ATTEND

A message from . . .

The President

PULL THE STRINGS, PUPPETEERS!

YOUR puppets are strung and on stage for another year. They will perform to your manipulations if you pull the strings. Without your help the performance can be a dull one, but with your support and voice they can dance a lively jig and sing a merry song.

The past year has been an opportunity to visit many areas of West Virginia and neighboring states which I had not enjoyed before. But the most enjoyable part of the year was the opportunity to meet and talk with many more of the physicians of the State.

I have stressed our need for unity of physicians in our dealing with governmental agencies, both State and Federal. This plea was not original with me, but actions and comments of physicians throughout the State emphasize the fact that we are not united in thought or actions and are probably more fragmented than ever.

Another aim was to improve communications upward from the members of the component societies to the Council and downward from Executive Committee and Council to the individual physicians. I must conclude that neither channel works as well as it should.

Increasing pressures and restrictions on physicians and the practice of medicine, especially with the pending implementation of the PSRO provisions of Public Law 92-603, may result in increased unity and more interest in communication. According to the law we have until 1976; everyone can get into the act. So on with the performance, puppeteers!

Worthy W. McKinney M.D.

W. W. McKinney, M. D., *President*

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EDITORIALS

THE 106th

By the time you read this editorial everything should be put together for the 106th Annual Meeting of the West Virginia State Medical Association. If you haven't made plans to attend the meeting at The Greenbrier we believe a close look at the convention program in this issue of *The Journal* will convince you that you should plan to join the some 700 persons who have already indicated they will be with us.

Dr. A. Thomas McCoy and the members of the Program Committee have worked for a year to plan sessions which are aimed directly at the scientific and business interests of family physicians, specialists and members of their families — not to mention the many out-of-state guests who will journey to The Greenbrier.

The Committee met initially at The Greenbrier last year and prepared the format for this year's meeting. Each member was assigned a task — and each responded beautifully. The next (and last) meeting was held on October 1. It took 25 minutes to finalize plans and the rest of the session drifted to the subject of the general election a month away.

We are delighted Gov. Arch A. Moore, Jr., accepted an invitation to deliver the Keynote Address — which this year and in future years will be entitled "The Thomas L. Harris Address." News of the institution of this address was reported editorially in the July issue of *The Journal.* Doctor Harris, who served as President of the Association in 1945, gave unselfishly of his services to the Association and his colleagues for more than 50 years. Prior to his death in 1972, he attended 50 consecutive annual meetings of the Association — with the exception of one year

Worthy W. McKinney, M. D.
President

while serving with the Medical Corps of the U. S. Army during World War I.

For those attending the meeting at The Greenbrier we can offer as speakers some of the most prominent physicians and surgeons in the country. There also will be sessions on matters of interest to practicing physicians and the Internal Revenue Service, a seminar on causes and prevention of malpractice claims, plus a discussion on continuing education and evaluation of performance of physicians in their daily practice.

Dr. Carl Hoffman's term as President of the American Medical Association came to an end during the Annual Convention in New York City during the month of June. We are proud to publish his Presidential Address which appears as the lead article in this issue of *The Journal.* It was everybody's intention to give Doctor Hoffman a rest at The Greenbrier this year, but he insisted as Chairman of the Association's Insurance Committee that he should serve as Moderator for the seminar on professional liability insurance.

Dr. Russell B. Roth, who succeeded Doctor Hoffman as President of the AMA, will be with us and will deliver an address at the first session of the House of Delegates on Wednesday afternoon, August 22.

Another honor guest will be Dr. James L. Grobe of Phoenix, Arizona, President of the American Academy of Family Physicians. A native of Huntington and a graduate of the two-year WVU School of Medicine, Doctor Grobe will participate in a "Symposium on Family Practice" on Saturday morning.

We won't probe further into the program in this space. We ask only that you examine the detailed report elsewhere in this issue, and we feel sure that you will want to take a few days off to both learn and relax at The Greenbrier.

Dr. Worthy W. McKinney's term of office as President of the Association will come to an end when he delivers his Presidential Address at the final session of the House of Delegates on Saturday afternoon.

It has been a long and trying year for the Association and organized medicine — and we are sure you know Doctor McKinney has been right in the thick of the battle. State and national legislation has never demanded more attention and your President has provided leadership to guide us in the right direction. He is to be commended for his service and we are glad he will continue to serve as Chairman of the Council during the coming year.

Doctor McKinney will be succeeded by Dr. A. Thomas McCoy of Charleston. Doctor McCoy is a native West Virginian and his face is familiar to thousands of persons throughout the State. He has done his homework and is well prepared to take over the helm.

The next 12 months — with implementation of PSRO, etc. — undoubtedly will be most difficult but in Doctor McCoy we will have a strong spokesman and leader. You can be sure he will speak his piece and it will be in the best interest of the Association.

Mrs. Robert G. Janes and the other officers of the Woman's Auxiliary deserve praise for their fine service to the community and the profession. During Mrs. Janes' term as President she has traveled far and wide to help build a stronger organization. We salute her for a job well done.

The Co-Chairmen of the Auxiliary's 49th Convention are Mrs. Kenneth D. Bailey and Mrs. Harry C. Fleming of Fairmont, and Mrs. Charles S. Harrison of Clarksburg. They have planned a fine program for the Auxiliary — including addresses by the Presidents of both the AMA Auxiliary and the Auxiliary to the Southern Medical Association.

As usual, the Auxiliary will be in charge of the entertainment program at The Greenbrier and the highlight will be a dance on Friday evening.

We urge everybody in attendance at The Greenbrier to spend some time each day touring the exhibits. Judging from advance descriptions, the industrial and scientific exhibits will be most attractive and interesting. We hope you will make it a point to talk with representatives of our exhibitors both in and outside of the Exhibit Center. Your discussions will prove to be mutually beneficial.

We'll see you at The Greenbrier!

AMA RULES ON M. D. NAME IN ADVERTISING

At its recent meeting in Washington, D. C., the AMA Judicial Council adopted the following reaffirmation of an existing opinion and asked that the reaffirmation be widely publicized:

From time to time in the past physicians have permitted the use of their names in commercial advertisements. It was not a widespread, frequent or accepted practice.

At this time the Judicial Council sees definite evidence of a break with ethical tradition. Commercial advertisement carrying the name, photograph and professional appointments of physicians are conspicuous in both public and professional periodicals.

Regardless of disclaimers and alleged educational claims for the ad, the intent of using a physician's name and photograph in an advertisement

is simply to draw attention to the ad. The physician who permits his name and photograph to be so used is permitting himself and his profession to be exploited.

The Judicial Council has previously stated that it is demeaning to the medical profession for the physician to permit the use of his name and professional status in the promotion of commercial enterprises. Out of respect for his profession, a physician should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

To the extent that the facts of a particular case indicate that the honor and dignity of the profession are denigrated then charges of conduct contrary to Section 4 of the Principles of Medical Ethics should be brought before and fully reviewed by the ethics committee of the physician's component medical society.

Circumstances will suggest and facts disclose whether some consideration of value was given the physician for the use of his name and photograph by the advertiser. Circumstances will indicate the purpose of the advertisement.

In view of the proliferation of advertising of this nature, the Judicial Council reaffirms its opinion:

> It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises.

In conclusion, the council condemns as unethical the action of the physician who *is found* to place personal, selfish, financial, or venal interests ahead of the high ideals of the medical profession. The council wishes to call this reaffirmation of its opinion to the attention of all physicians and to all ethical medical publications.—*Adopted by the AMA Judicial Council, April 28, 1973.*

BURKITT'S LYMPHOMA

There are diseases and conditions of men which bear the name of the individual who first described them, such as Cushing's Disease, Graves' Disease, Osler's Disease, Parkinson's Disease and a host of others. There also are certain anatomic structures in the body which bear the name of the person who described them; a few are euphonious and have a rather grand sound, such as the antrum of Highmore. There are, too, of course, many surgical operations named after doctors. We will, however, restrict this essay to names of diseases which bear the name of an individual.

Recently a distinguished English surgeon, Mr. Denis Burkitt, presently with the Medical Research Council and External Scientific Staff in London, visited West Virginia and spoke before the faculty and student body of the Medical Center and later before the members of the Monongalia County Medical Society and its guests. He bears the distinction of having a disease associated with his name, namely a lymphoma. There are, of course, several types of lymphoma, but the type he observed and described in children in Uganda, Africa will undoubtedly bear his name.

The occurrence seldom arises when such a famous visitor comes to our State. In fact, during the past 50 years the author of this essay can recall only two men who spoke in the State whose names were associated with a disease; Mr. Denis Burkitt was one and Dr. Paul D. White of Boston the other. There may have been others whom I have overlooked.

The question has been raised as to the advisability of linking the name of an individual with a disease process. It has been pointed out that it is irrational and confusing and makes it necessary for the student to remember two things instead of one, that is, the name of the disease and the man's name. There is something to be said for this argument, because the poor medical student has so many things to remember. On the other hand, the mind is practically limitless, and too, some of the men's names associated with the disease are easier to remember than the disease itself. The two that come to mind are Cushing's Disease and Parkinson's Disease; furthermore, in some instances it takes more than one phrase to describe the disease. This applies especially to Cushing's Disease, although it does not always hold true; for example Osler's Disease (more correctly Osler-Vaquez Disease) can be expressed in one word — polycythemia.

In summary, to link a man's name with a disease may be regarded with disfavor. The purist would deem it unscientific and a distinct step backward. He is probably right and we respect his point of view. On the other hand, it is almost impossible to change the custom of associating a man's name with certain diseases. We bow to the purist, but are inclined presently, at least, to accept the inevitable and believe that if this is a step backward, it is not an unpleasant step.

GENERAL NEWS

Governor Moore, Dr. Russell Roth Head Annual Meeting Guests

Gov. Arch A. Moore, Jr., and Dr. Russell B. Roth of Erie, Pennsylvania, will have featured roles when the West Virginia State Medical Association holds its 106th Annual Meeting this month.

Doctor Roth, installed as the American Medical Association's 128th President in June, will address the first session of the Association's House of Delegates at 2:30 P.M. on Wednesday, August 22—the meeting's opening day—at The Greenbrier in White Sulphur Springs.

Governor Moore will deliver the initial "Thomas L. Harris Address" as the keynote speaker for 9 A.M. opening exercises which will precede the first general scientific session on Thursday, August 23, in Governor's Hall.

The Annual Meeting will continue through Saturday afternoon, August 25, when Dr. A. Thomas McCoy, Charleston urologist, will be inaugurated during the second and final House of Delegates session to succeed Dr. Worthy W. McKinney of Beckley as the Association's President.

Doctor Roth, who succeeded Dr. C. A. (Carl) Hoffman of Huntington as AMA President, is at the summit of a career marked by more than two decades of service to his county and state medical societies, and the AMA. Like Doctors Hoffman and McCoy, he is a practicing urologist.

The son of a surgeon, the 59-year-old Pennsylvanian is a graduate of Yale and received his M.D. degree in 1939 from Johns Hopkins University in Baltimore. He now shares a medical practice with four other urologists in Erie, and the partnership has six residents in training.

Prior to becoming President Elect of the AMA a year ago, Doctor Roth was Speaker (1969-72) and Vice Speaker (1966-69) of the AMA's House of Delegates.

A former Chairman of the AMA's Council on Medical Service and with service on several AMA committees, Doctor Roth is a Past Chairman of the Board of Trustees and Councilors of the Pennsylvania Medical Society. For four years, he was Speaker of the PMS House of Delegates, and currently is a member of the PMS Judicial Council.

Governor Moore, a Moundsville native with a degree from West Virginia University's College of Law, was elected as West Virginia's 28th chief executive in 1968. He was reelected in 1972 as the first Governor in the State's history to succeed himself for another four-year term.

Provisions for the address Governor Moore will deliver were included in the will of the late Dr. Thomas L. Harris of Parkersburg, who served as the State Medical Association's President in 1945. The bequest in his will established a trust fund to enhance the quality of programs for the Association's annual meetings.

Presidential Address

Doctor McKinney, who is an ophthalmologist in Beckley, will deliver his address as the retiring Association President prior to the inauguration of Doctor McCoy at the final House session on Saturday afternoon.

Pre-Convention Meetings

As has become the practice over the past several years, the Association's Council will have what like-

Russell B. Roth, M. D.

Convention Timetable

The first general scientific session will begin at 9 A.M. on Thursday, August 23. The Friday session will begin at 9:30 A.M., and the session on Saturday, also at 9:30 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 22, beginning at 2:30 o'clock. The second session will be on Saturday afternoon beginning at 2:30 o'clock.

The Exhibit Center will be open from 8:30 A.M. to 3:30 P.M. on Thursday and Friday and from 8:30 A.M. to noon on Saturday.

wise amounts to an annual meeting at 10 A.M. on Wednesday, August 22, with its Chairman, Dr. Harry S. Weeks, Jr., of Wheeling presiding. The first House session will follow in Chesapeake Hall at 2:30 P.M., as noted earlier, with Doctor McKinney as presiding officer.

From 6:30 until 7:30 P.M. on Wednesday evening, a President's Reception will be held on the Chesapeake Hall Terrace for honor guests.

General Scientific Sessions

All three of this year's general scientific sessions will be held in Governor's Hall in the West Virginia Wing of The Greenbrier, with the first at 9:45 A.M. on Thursday, August 23. The other two sessions will follow at 9:30 A.M. on Friday and Saturday.

Scheduled for Thursday and Friday afternoon in Governor's Hall, the Mountaineer Room and the Convention Unit are several meetings of scientific sections, affiliated societies and other Association groups and committees.

The Exhibit Center, in the West Virginia Wing outside Governor's Hall and the Mountaineer Room, again will be the scene of industrial and scientific exhibits.

Scientific Motion Pictures

Dr. David Z. Morgan of Morgantown, Chairman of the Scientific Motion Picture Program, has arranged for the showing of medical films at 8 A.M. Thursday through Saturday in Governor's Hall, prior to the three general scientific sessions.

Luncheon for Past Presidents

A luncheon honoring Past Presidents of the West Virginia State Medical Association will be held at The Greenbrier on Thursday, August 23, during the 106th Annual Meeting.

Dr. Harry S. Weeks, Jr., of Wheeling, Immediate Past President, will preside, and invitations have been extended to all the Association's living Past Presidents.

Gov. Arch A. Moore, Jr.

Formal Opening Exercises

Doctor McKinney will call the Annual Meeting to order at the 9 A.M. session on Thursday, with Dr. William E. Gilmore of Parkersburg to give the invocation and Doctor McCoy, Chairman of the Program Committee, to offer welcoming remarks before Governor Moore's address.

Dr. William H. Carter, Charleston cardiologist, will then serve as Moderator for a "Symposium on New Concepts of The Medical and Surgical Treatment of Coronary Artery Disease" which will constitute the first scientific session program. Symposium speakers and their subjects will include:

Dr. C. Richard Conti, Associate Professor of Medicine, Johns Hopkins University School of Medicine, "Medical Therapy of Angina Pectoris;" Dr. James J. Morris, Jr., Associate Professor of Medicine, Duke University School of Medicine, "Angiographic and Hemodynamic Aspects of Coronary Artery Disease;" and Dr. William H. Muller, Jr., Professor and Chairman of the Department of Surgery, University of Virginia School of Medicine, "Surgical Aspects of Coronary Artery Disease."

Thursday Afternoon Activities

A 12:30 P.M. luncheon on Thursday will honor Past Presidents of the Association, with Doctor Weeks presiding over those festivities in the Tyler Room.

The Resolutions Committee, with Dr. Richard E. Flood of Weirton presiding, will meet at 2 P.M. in the West Virginia Room; and scheduled for the same hour in the Fillmore and Van Buren Rooms is an open meeting on "Matters of Interest to Practicing Physicians and the Internal Revenue Service."

Mr. Mortimer M. Caplin, senior partner in the Washington, D. C., law firm of Caplin & Drysdale,

A. Thomas McCoy, M. D.

will address the open session with Dr. Philip M. Sprinkle of Morgantown presiding.

A "Seminar on the Causes and Prevention of Malpractice Claims," with Doctor Hoffman presiding as Chairman of the Association's Insurance Committee, will be held at 3:30 P.M. in the Tyler Room.

Speakers will be Dr. David C. Kellsey; D. John Pecorino, L.LB., and Mr. F. M. Taylor, all staff members of Aetna Casualty and Surety, Administrator for the State Medical Association's Group Liability Insurance Program.

Friday Morning Program

An 8 A.M. breakfast meeting of the West Virginia Academy of Ophthalmology and Otolaryngology in the Washington Room of the Virginia Wing will get Friday activities under way.

Dr. C. Richard Daniel of Beckley then will serve as Moderator for the second general scientific session, with speakers and their topics for the 9:30 program to include:

Dr. Theodore M. King, Professor and Director of the Department of Gynecology and Obstetrics at Johns Hopkins University School of Medicine, "Abortifacients—Efficacy and Untoward Effects;" Dr. Alvin L. Watne, Professor of Surgery, West Virginia University School of Medicine, "Colon Polyposis and Colon Cancer;" and Dr. John A. Kirkpatrick, Jr., Professor of Radiology and Pediatrics, Temple University School of Medicine in Philadelphia, "Respiratory Obstruction in Differential Diagnosis and Diagnostic Techniques."

Schedule for Friday Afternoon

A 12:15 P.M. meeting of the Association's Cancer Committee in The Greenbrier's Main Dining Room will be followed by meetings of numerous sections and affiliated societies. Scheduled for 2 P.M. are the following:

Section on Internal Medicine, Governor's Hall, with Dr. Thomas O. Dotson, White Sulphur Springs, presiding. Dr. James J. Morris, Jr., of Durham, North Carolina, will discuss "Survival After an Acute Myocardial Infarction," and Doctor Conti will speak on "Unstable Angina."

Joint meeting of the West Virginia Radiological Society and the Section on Pediatrics and West Virginia Chapter, American Academy of Pediatrics, Fillmore and Van Buren Rooms, with Drs. Joseph N. Aceto of Wheeling and Barbara Jones of Morgantown presiding and Doctor Kirkpatrick speaking on "Neoplasia and Associated Abnormalities in Infants and Children."

Section on Surgery, Mountaineer Room, with Dr. Maynard P. Pride of Morgantown presiding and Doctor Muller speaking on "Thymectomy for Myasthenia Gravis."

Section on Neurology, Neurosurgery and Psychiatry, Director's Room, Dr. Ludwig Gutmann of Morgantown presiding and Dr. Samuel M. Chou, Professor of Neuropathology at the WVU School of Medicine, to discuss "Slow Viruses and 'Degenerative' Brain Disease."

Section on Orthopedic Surgery, Washington Room, Dr. Robert R. Weiler, Wheeling, presiding, with Dr. John B. Blakley of Allegheny General Hospital in Pittsburgh to discuss "Indications for and Results of Anterior Cervical Fusions."

Section on Urology, Jackson Room, with Dr. Harold N. Kagan, Huntington, presiding.

At 3 P.M., the West Virginia Chapter, American Society of Internal Medicine, will meet in Governor's Hall with Dr. Leo H. T. Bernstein of Martinsburg presiding.

The West Virginia District Branch, American Psychiatric Association, will hold a 3:30 P.M. meeting in the Director's Room with Dr. Thomas S. Knapp of Charleston presiding.

Also at 3:30 P.M., in the West Virginia Room, there will be an open meeting on "Qualifying Evaluation of the Medical Graduate Including the

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at The Greenbrier will be convened at 2:30 P.M. on Wednesday, August 22. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 25.

The 1973 Program Committee

Dr. A. Thomas McCoy of Charleston is Chairman of the Program Committee for the 106th Annual Meeting of the West Virginia State Medical Association. Other members of the Committee are Drs. William H. Carter of Charleston, C. Richard Daniel of Beckley, Robert G. Janes of Fairmont, Philip M. Sprinkle and J. Hugh Wiley, both of Morgantown.

Foreign Medical Graduate—With a Look to the Continuing Evaluation and Re-Certification of Physicians." Drs. Richard E. Flood and Maynard P. Pride will preside, with the speaker to be Dr. William A. Sodeman of Philadelphia, Chairman of the AMA Council on Medical Education.

The Association's Committee on Nominations will cap the heavy Friday afternoon schedule with a 5 P.M. meeting in the Lee Room at which Dr. George R. Callender, Jr., of Charleston will preside.

Saturday Morning Session

A "Symposium on Family Practice" with Dr. Clark K. Sleeth of Morgantown as Moderator will make up the third general session on Saturday morning. Other participants at this 9:30 A.M. session will be:

Dr. James L. Grobe, Phoenix, Arizona, President of the American Academy of Family Physicians; Dr. Richard W. Lindsay, Chairman of the Department of Family Practice, University of Virginia School of Medicine in Charlottesville; and Dr. Wyn Rhys-Jones, Department of Family Practice, University of Ottawa, Canada, and the Ottawa Civic Hospital.

Doctor Sleeth is Acting Chairman of the new Department of Family Practice at the WVU School of Medicine.

Second House of Delegates Session

Doctor McKinney again will be the presiding officer at the second and final House of Delegates Session in Chesapeake Hall at 2:30 P.M. on Saturday.

Along with his Presidential Address and the inauguration of Doctor McCoy, the agenda will include election of other Association officers and consideration of several resolutions and other business items.

No Convention Registration Fee

No registration fee will be charged either members or guests in connection with the 106th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22-25.

Nominating Committee To Meet On Friday, Aug. 24

The State Medical Association's Committee on Nominations will hold a 5 P.M. meeting on Friday, August 24, in the Lee Room of The Greenbrier.

The Committee will make nominations to the House of Delegates for President Elect, Vice President and Treasurer, and for Delegate and Alternate Delegate to the American Medical Association.

Association By-Laws also provide that nominations may be made from the floor for these offices, to be filled by the House in balloting at its final session on Saturday, August 25, the final day of the Association's 106th Annual Meeting.

Dr. George R. Callender, Jr., of Charleston will serve as Chairman of the Committee on Nominations, with other members to include: Drs. Stephen D. Ward, Wheeling; Charles E. Andrews, Morgantown; Carl A. Liebig, Keyser; J. D. H. Wilson, Clarksburg; Joseph B. Reed, Buckhannon; and John J. Mahood, Bluefield.

In addition, one of the Kanawha Medical Society's two Councilors will serve on the Committee under provisions of the By-Laws, but that representative had not been announced as this issue of *The Journal* went to press.

Medical School Alumni Events

The West Virginia University School of Medicine's Alumni Association; the University of Virginia Alumni Fund, Medical Division; and the West Virginia Chapter, Medical College of Virginia Alumni Association will hold cocktail parties on Thursday evening, August 23.

Doctor Sleeth will be in charge of the WVU festivities in the Fillmore and Van Buren Rooms at 6 P.M., with Dr. E. L. Crumpacker of White Sulphur Springs in a similar role for the University of Virginia affair at the same hour.

Dr. R. S. Birckhead of Gauley Bridge will be in charge of the Medical College of Virginia event at 6:30 P.M. in the Old White Club.

Friday Night Auxiliary Dance

"Futura Fantasy" will be the theme of the annual dance to be sponsored by the Woman's Auxiliary to the State Medical Association at 10 P.M. Friday in Chesapeake Hall. The Marion County Auxiliary, with Mrs. J. T. Mallamo serving as Chairman, will host the dance.

Saturday Evening Reception

New officers of the State Medical Association will be honored at a cocktail party and reception from 6:30 to 7:30 P.M. on Saturday on the Chesapeake

Hall Terrace. All members of the Association and Auxiliary and their families, representatives of the industrial and scientific exhibitors and convention guests are cordially invited.

Industrial, Scientific Exhibits

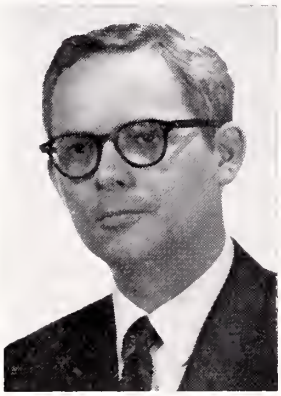
Physicians, members of the Auxiliary and their guests are urged to visit the many interesting industrial exhibits which again will be featured in the Exhibit Center during the annual meeting. The Center will be open from 8:30 A.M. to 3:30 P.M. on Thursday and Friday, and from 8:30 A.M. until noon on Saturday.

Heavy Advance Registration

Advance registration for The Greenbrier sessions has been heavy, in line with the trend over the past several years. As this issue of *The Journal* went to press, more than 650 persons had made their reservations.

Dr. Jones Named Acting Dean At WVU School of Medicine

The appointment of Dr. John E. Jones as Acting Dean of the West Virginia University School of Medicine was announced in early July by WVU President James G. Harlow.



John E. Jones, M. D.

Doctor Jones was named to fill the vacancy created by the resignation of Dr. Frank W. McKee as Dean.

A member of the School of Medicine faculty since 1961, Doctor Jones is Professor of Medicine and Chairman of that department's Metabolism - Endocrinology Division.

He was born in Mt. Pleasant, Utah, and is a graduate of the University of Utah College of Medicine. He completed his internship at the University of Minnesota Hospital, began his residency there in internal medicine and then served for two years in the Medical Corps of the United States Navy. He returned to Minnesota to continue a residency at Minneapolis Veterans Administration Hospital and concluded his specialty training in 1961 at WVU as a United States Public Health Trainee in Endocrinology.

Doctor Jones is a Fellow of the American College of Physicians and holds membership in The Endocrine Society, Central Society for Clinical Research, American Society of Clinical Nutrition, American Institute of Nutrition and the American Federation for Clinical Research.

He is author or co-author of 31 scientific publications and served as Acting Head of the Department of Medicine during the 1972 sabbatical of Dr. Edmund B. Flink, Professor and Chairman.

Golf, Tennis Play Scheduled For Doctors, Auxiliary

Golf and tennis competition for both State Medical Association members and their wives again will be held in conjunction with annual meetings of the Association and its Auxiliary at The Greenbrier in August.

Dr. L. Dale Simmons of Clarksburg shot a 74 to edge Dr. Joseph T. Mallamo of Fairmont by one stroke for low gross honors in last year's Medical Golf Tournament. Dr. William C Morgan, Jr., of Charleston had the low net score, a 70.

Mrs. Maxine Gilmore of Parkersburg, with a 76, won the low gross title in the women's golf play a year ago. The men's tennis competition was won by the doubles team of Drs. George R. Callender, Jr., of Charleston and George R. Mayfield of Columbia, Tennessee, formerly of Charleston.

Women's honors, in play also limited to doubles, went to Mrs. Marge Revercomb of Charleston and Mrs. Betty Blaydes of Bluefield.

Specific starting time and other rules will be in effect for this year's tennis and golf play, and those planning to take part should make certain they are familiar with those rules.

Dr. Joseph A. Smith of Dunbar, Chairman for the men's Medical Golf Tournament, said a $5 entry fee again will be charged. Competing physicians may play their rounds during any morning or afternoon

Meeting Subjects Include Taxes, Recertification, Malpractice

Three open meetings on subjects of major interest to physicians will be offered those attending the August 22-25 Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs.

One, at 2 P.M. on Thursday, August 23, will deal with "Matters of Interest to Practicing Physicians and the Internal Revenue Service" with Washington, D. C., attorney Mortimer M. Caplin as the speaker. Mr. Caplin served as U. S. Commissioner of Internal Revenue for four years.

At 3:30 P.M. on Friday, August 24, Dr. William A. Sodeman of Philadelphia, Chairman of the American Medical Association's Council on Medical Education, will speak on matters including physician recertification.

Also of particular interest will be a 3:30 P.M. "Seminar on the Causes and Prevention of Malpractice Claims" on Thursday, with speakers to include staff members of Aetna Casualty and Surety, Administrator for the Medical Association's Group Liability Insurance Program.

on Thursday through Saturday, August 23-25, but must inform the starter when they begin their official 18 holes. All tournament play must be completed by 4 P.M. on Saturday to permit the awarding of prizes during an evening reception honoring new Medical Association officers.

Dr. Lynch Receives Promotion In Air Force Reserve

Dr. Richard V. Lynch, Jr., Assistant Professor of Medicine and Medical Director of the Outpatient Department at the West Virginia University School of Medicine, recently was promoted to the grade of Colonel in the U. S. Air Force Reserve.

Doctor Lynch, a Past President of the State Medical Association, is the Air Force medical service liaison officer at the medical school and Commander of the 911th Tactical Clinic in Pittsburgh. He has completed his second term as Surgeon for the West Virginia Department of the Reserve Officers Association, and at the group's annual meeting last spring in Charleston was elected Vice President for Air.

Cleveland Clinic Lists 1973-1974 Postgraduate Courses

The postgraduate course schedule for 1973-1974 has been announced by the Cleveland Clinic Educational Foundation.

"Dermatology for the Non-Dermatologist," October 10-11; "Current Status in Artificial Organs," October 19-20; "Pediatric Endocrinology," October 24-25; "Gastroenterology," November 14-15; "Advances in Ophthalmology," December 5-6;

"Gastrointestinal Surgery," January 16-17; Medical Progress for the Family Physician," January 30-31; "Blood Banking," February 6-7; "Current Concepts in Renal Disease and Hypertension," February 13-14; "Diagnostic and Therapeutic Approach to Rheumatic Disease," February 20-21;

"Sports Medicine," February 27-28; "Medical Progress and Its Relationship to Dentistry," March 6-7; "Advances in Urology," March 13-14; "Refresher Seminar in Pediatrics for Pediatricians and General Practitioners," March 20-21; "Endocrine Pathology — Anatomic and Clinical," March 27-28;

"The Challenges of Reconstructive Orthopaedic Surgery," April 3-4; "Infection Control," April 17-18; "Symposium on Hydrocephalus Pathogenesis, Diagnosis and Treatment," May 1-2; "Plastic Surgery for the General Surgeon," May 8-9; "Advances in Antibiotics and Infectious Diseases," May 22-23.

These programs in continuing medical education are accredited by the American Medical Association and are acceptable for Category 1 credit toward the AMA Physician's Recognition Award.

For further information and detailed programs write: Director of Education, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44106.

Lewis Returns To Association In New Position

The appointment of Charles R. Lewis of Charleston to a new West Virginia State Medical Association position has been announced by Dr. Harry S. Weeks, Jr., of Wheeling, Chairman of the Association's Council.

Doctor Weeks said Mr. Lewis, who was the Association's Executive Assistant from 1970 to 1972, will assist physicians in development of new professional standards review mechanisms under provisions of 1972 federal legislation. He also will have related responsibilities in some areas of medical education.

Charles R. Lewis

Mr. Lewis, a native of Middleport, Ohio, and an Ohio University graduate, has served as Executive Director for the West Virginia Railroad Association for the last eight months. He was an Associated Press newsman in West Virginia for 17 years, and Executive Secretary of the West Virginia Department of Welfare for seven years.

Mr. Lewis, who started his newspaper career on the Canton (Ohio) Repository, was legislative and capitol correspondent for the Charleston Bureau of the Associated Press. He has been an active member and officer of the West Virginia Welfare Conference and other welfare organizations. He and Mrs. Lewis, the former Miss Jane Ann Veazey of Charleston, are the parents of two sons and three daughters.

Annual Heart Association Meeting In September

Hypertension with emphasis on epidemiology, diagnosis and treatment, will be the theme of the Scientific Sessions held in conjunction with the Annual Meeting of the West Virginia Heart Association September 14 and 15 at the Heart-O-Town Motor Inn in Charleston.

Included on the program of the symposium on hypertension, with all medical sessions being held on Saturday, September 15, will be several outstanding speakers. Robert C. Tarazi, M. D., Department of Medicine, Cleveland Clinic Foundation, will use as his subject, "End Organ Involvement in Hypertension." Mrs. Ellen L. Hathaway, R. N., Administrative Assistant to Dr. Frank A. Finnerty, Jr., M.D., Professor of Medicine at Georgetown University Medical Division, will speak on "Hypertensive Screening in Washington, D. C." The subject for Alvin P. Shapiro, M. D., Dean, School of Medicine, University of Pittsburgh, will be "Current Drug Treatment of Hypertension."

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1973:

Brooke

Peralta-Velarde, Leticia — Follansbee
Velarde, Rogelio, L. — "

Cabell

Arya, Sirous — Huntington
Avery, A. Parke — "
Castillo, Julian V., Jr. — "
Daniels, James D. — "
Hamlin, Charles R. — "
Walden, John B. — West Hamlin

Central W. Va.

Evangelista, Juan N. — Richwood

Eastern Panhandle

Kapcar, Andrew J. — Martinsburg
Orquiza, Danilo S. — "

Fayette

Ghofrani, Mohammad — Montgomery
Gonzales, Adelaido M. — "
Maducdoc, Serafino S., Jr. — Oak Hill
Nayak, S. P. — Montgomery
Sanchez, Segundo — "

Hancock

Clements, Harry M. — Weirton
Espiritu, Mario — New Cumberland
Makar, Jasbir S. — Weirton
Montero, Pedro R., Jr. — Chester
Tayal, Hari N. — Weirton

Harrison

Ahmed, Rashid — Bridgeport
Aragones, Peter C. — "
Fiester, Richard F. — Clarksburg
Gannod, Godofredo G. — Romulus, Mich.
Lustig, Karl Anton — Bridgeport
Mahmoodian, M. Saeed — Clarksburg

Kanawha

Arce, Jose B. — Charleston
Arceo, Constantino C. — "
Davis, Wirt Lee — "
Gruspe, Arnold F. — "
Lim, Rogelio T. — "
Lin, Hsin Lang — Ripley
McMillan, William O., Jr. — Charleston
Merrifield, John V. — Dunbar
Nakatsuka, Mitsuru — Charleston
Rao, Pejawar M. — "
Smith, James T. — "
Steele, Ida May H. — Nitro
Uy, Isidro P. — Charleston
Verma, P. L. — "

Logan

Almase, Luis A. — Man
Camargo, Carlos E. — "
Ceniza, Rosario P. — Logan
Ceniza, Silverio — "
Chan, Henry Shou-Houng — Man
Collantes, Melchor M. — Logan
Kieryl, Anna M. — Man
Mier, Jose F., Jr. — Danville, Va.
Onder, Kebuter — Man
Rallos, Enrico V. — "

Marshall

Bastug, Erol — Glen Dale
Luna, Ignacio, Jr. — " "
Taruc, Martin O. — Moundsville

Mercer

Bruch, William M. — Bluefield
Hajjar, Mohamed S. — "
Koh, Yung H. — Princeton
McGan, Richard W. — "
Serra, H. B., Jr., — Bluefield
Weaver, James M. — Princeton

Mingo

Hooper, Anne C. D. — Williamson
Hooper, William Dale — Beckley

Monongalia

Bowyer, Allen F. — Morgantown
Davis, Charles M., Jr. — "
Hein, Peter L., Jr., — "
Klainer, Albert S. — "
Marshall, Robert J. — "
Morgan, Wm. Keith C. — "
Sontheimer, Gary G. — "

Ohio

Hacker, Mortimer — Wheeling
Keefer, F. Jay — "
Parmar, Jaywant P. — "
Pellizzari, Mario L. — "
Stupar, Ronald K. — "
Thupvong, Chawtipya — "

Parkersburg Academy

Atkinson, Billie M. — North Parkersburg
Canario, Jose R. — Sistersville
Lawrence-Berrey, Robert E. — Parkersburg
Long, Robert W. — "
Lundblad, Daniel M. — "
Ocampo, Luis H. — "
Ralsten, John N. — "
Rugonfalvy, Lenke M. — Spencer
Sams, Robert E. — Parkersburg
Santer, Michael A., Jr. — "

Potomac Valley

Bensenhaver, Dewey F. — Petersburg

Raleigh

Ma-Luf, T. J. — Beckley
Ramas, Mario C. — "
White, Byrd E., Jr. — "

Summers

Bencosme, Persio A. — Morgantown

Tygart's Valley

Kreider, Elvin G. — Philippi
Kwak, Dong L. — Elkins
Lee, Chi Menn — "

Wyoming

Reodica, Solomon D. — Mullens

Internal Medicine Course Scheduled By ACP

"Advances in Internal Medicine," a postgraduate course of the American College of Physicians," will be held September 17-21 at the University of California, San Francisco.

The program will consist of four full-day sessions and one two-thirds day session devoted to areas of special interest in Internal Medicine. Topics will be chosen in Cardiology, Gastroenterology, Chest Medicine, Endocrinology-Metabolic Diseases, Renal and Electrolyte Disorders, Rheumatic Diseases, Infectious Diseases, and Clinical Pharmacology.

For registration forms and further information contact Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

AMA 'Reaffirms' Important Policies, Elects Dr. Todd

A large number of West Virginia physicians were among the 8,756 physicians attending the American Medical Association's 122nd Annual Convention in New York in June. The total registration was 21,543.

In his last address to the House of Delegates, outgoing President C. A. Hoffman, M. D., of Huntington, called on physicians to "preserve this House of Medicine, for only it can preserve your future" (See full text of Doctor Hoffman's address on Page 191).

Dr. Russell B. Roth of Erie, Pennsylvania was installed as the AMA's 128th President. In his inaugural address, Doctor Roth pointed out that the profession has many societal obligations and responsibilities and that "the individual physician can do little about them on his own." Only through "the collective actions of organized physicians can these jobs be done," he said. Doctor Roth said the AMA is turning back the drive for "a compulsory national medical care delivery law that would promise what could not be delivered, at a price we would be reluctant to pay, through a vast new administrative bureaucracy."

Malcolm C. Todd, M. D., of Long Beach, California was named President Elect and E. Bryce Robinson, M. D., Fairfield, Alabama, Vice President. Dr. Tom E. Nesbitt of Nashville, Tennessee was elected Speaker of the House of Delegates. Dr. William Y. Rial of Swathmore, Pennsylvania was elected Vice Speaker.

Doctor Todd, a native of Illinois, is a general surgeon. He is an Associate Clinical Professor of Surgery at the University of California in Irvine. He is a Fellow of the American College of Surgeons, International College of Surgeons, American College of Gastroenterology, and a Diplomat of the American Board of Surgery.

The AMA's policy of cooperative leadership in the development of PSRO's was reaffirmed by the House of Delegates, although efforts to repeal the legislation also were called for.

In other actions, the House:

- Voted to give representatives of the Intern-Resident Session seats on two important bodies: the Council on Medical Education and the Council on Medical Service. The AMA also decided to establish a new Committee on House Staff Affairs, designed to strengthen participation by the nation's interns and residents in the AMA.
- Reiterated medicine's traditional opposition to the withholding of medical services as a bargaining mechanism, and asserted that self-employed physicians do not need a union to advance their interests.
- Expressed concern about incidents where hospital boards have attempted to set medical policies, and expressed "grave reservations" about the American Hospital Association's Quality Assurance Program because of its potential for lay control.
- Continued to protest the Food and Drug Administration's regulatory activities that restrict the use of prescription drugs to conditions and doses contained in package insert, or that "threaten to interfere with the exercise of physician's professional prerogatives."
- Called for improved education program capable of producing more primary care physicians; included was the recommendation that at least 50 per cent of all graduates enter residency training in primary care specialties.
- Reaffirmed the AMA's 1970 policy on abortion, with emphasis on medicine's "positive attitude toward life itself" and alternatives to abortion. In essence, the policy requires that abortion be performed in accordance with "good medical practice."

Scalpel and scissors in hand, Dr. Carl A. Hoffman of Huntington, left, American Medical Association President, and William E. Lotterhos, M. D., Chairman of the Council on Scientific Assembly, officially opened the scientific exhibit section of the Association's 122nd Annual Convention in New York City, Saturday, June 23.

Getting together for a few minutes immediately following the annual breakfast meeting of the Aces and Deuces held at the AMA convention in New York were, from left, Drs. Carl A. Hoffman of Huntington, AMA President; Ralph H. Riggs of Shreveport, Louisiana, President of Aces and Deuces; Russell B. Roth of Erie, Pennsylvania, AMA President Elect; Frank J. Holroyd of Princeton, Secretary-Treasurer of Aces and Deuces; and Eugene C. St. Martin of Shreveport, honor guest and speaker at the meeting.

Auxiliary Completes Program For 49th Convention

Mrs. Willard C. Scrivner of Belleville, Illinois, will be among honor guests and speakers when the Woman's Auxiliary to the West Virginia State Medical Association holds its 49th Annual Meeting at The Greenbrier in White Sulphur Springs August 22-25.

Mrs. Willard C. Scrivner

Mrs. Erle E. Wilkinson

The meeting again will be held concurrently with the Annual Meeting of the Medical Association. Mrs. Scrivner was installed in New York in June as the new President of the Woman's Auxiliary to the American Medical Association.

Also addressing the Auxiliary will be Mrs. Erle E. Wilkinson of Nashville, Tennessee, President of the Woman's Auxiliary to the Southern Medical Association.

More than 200 wives of physicians are expected to attend the Auxiliary's business sessions, over which Mrs. Robert G. Janes of Fairmont, the State Auxiliary's President, will preside.

Pre-Convention Meetings

Mrs. Janes said that a cordial invitation has been extended to Auxiliary members to attend the first session of the Medical Association's House of Delegates on Wednesday, August 22, at 3 P.M., when the principal speaker will be Dr. Russell B. Roth, President of the American Medical Association.

Mrs. Janes then will preside at a 4 P.M. pre-convention Auxiliary Board meeting in the Fillmore and Van Buren Rooms.

Opening Convention Exercises

Members of the Auxiliary also have been invited to attend formal opening ceremonies of the Medical Association's 106th Annual Meeting at 9 A.M. on Thursday, August 23, in Governor's Hall. The Hon. Arch A. Moore, Jr., Governor of West Virginia, will present the first "Thomas L. Harris Address."

Following the opening exercises, the Auxiliary members will go to the Fillmore and Van Buren Rooms for the formal opening of their convention, with Mrs. Janes in charge.

First Business Session

The keynote address by Mrs. Scrivner will highlight the initial business session at 9:45 A.M., and Dr. Worthy W. McKinney of Beckley, President of the West Virginia State Medical Association, will be presented to the Auxiliary.

Other opening-session items will include the introduction of the convention co-chairmen, Mrs. Kenneth D. Bailey and Mrs. Harry C. Fleming of Fairmont, and Mrs. Charles S. Harrison of Clarksburg; reports from officers and committee chairmen, recommendations from the pre-convention Board meeting, election of the 1974 Nominating Committee, and introduction of component Auxiliary Presidents by the Regional Directors.

The Keynote Speaker

Mrs. Scrivner has been national Auxiliary First Vice President, a Director, Chairman of the Home-Centered Health Care Committee, and North Central Regional Vice President. She was President of her state auxiliary, as well as serving as Vice President, a District Councilor, a Director and Chairman of the Revisions and Resolutions committees. A member of her county auxiliary since 1934, she was President of that organization in 1952-53, and has served many chairmanships.

She has been active in other community activities, being the first woman to be elected to her area school board. She was appointed to the White House Conference on Aging by the Illinois governor in 1972.

A native of East St. Louis, Illinois, Mrs. Scrivner attended Washington University School of Nursing in St. Louis, Missouri, where she received her R.N. She received a B. S. Degree from Missouri University.

Doctor Scrivner, a gynecologist and obstetrician, is 1973-74 President of the Illinois State Medical Society. They have two children, Peter C. Scrivner, Administrative Assistant to Congressman Melvin Price in Washington, D. C.; and Roger M. Scrivner, an attorney in Belleville.

Bridge, Presidents' Breakfast

The Cabell County Auxiliary will serve in a hostess role, with Mrs. A. C. Esposito as Chairman, for a bridge tournament beginning at 2 P.M. on Thursday in the Trellis Lobby.

On Friday, August 24, at 8 A.M., the Past Presidents' Breakfast will be held, with Mrs. M. Bruce Martin of Huntington, Immediate Past President of the Auxiliary, presiding.

Second Business Session

The Second General Session at 9:45 A.M. on Friday in the Fillmore and Van Buren Rooms again will have Mrs. Janes presiding with a highlight to be the address by Mrs. Wilkinson.

A native of Charlotte, North Carolina, Mrs. Wilkinson received a B. S. degree in nursing from Vanderbilt University in Nashville. She is a former President of the Galveston County (Texas) Aux-

iliary, the Auxiliary to the Tennessee Medical Association, and is a past Chairman of the AMA-ERF Committee of the Auxiliary to the American Medical Association.

Mrs. Wilkinson is a Sustaining Member of the Junior League of Nashville, Inc., and a Past President of the Vanderbilt University School of Nursing Alumni Association, the Nashville Children's Theater, Association for the Preservation of Tennessee Antiquities, Nashville Chapter; and is a Board Member of the Historic Sites Federation of Tennessee.

Her husband is a pediatrician.

Other activities at the Second General Session will include the presentation of the AMA-ERF Awards to the Auxiliary by Acting Dean John E. Jones of the West Virginia School of Medicine, and Mrs. Robert R. Weiler of Wheeling, Chairman. Mrs. William J. Reardon of McLean, Virginia, Eastern Regional AMA-ERF Chairman, also will participate.

Mrs. Scrivner will install Mrs. J. Dennis Kugel of Charleston as the new Auxiliary President; other officers will be elected after a report from the Nominating Committee, and Mrs. Janes will receive the Past President's Pin from Mrs. Martin.

Friday Social Functions

The Central West Virginia Auxiliary, with Mrs. Louis Groves of Richwood serving as Chairman, will be hostess for golf on Friday afternoon, and the Mercer County Auxiliary, with Mrs. J. E. Blaydes, Jr. of Bluefield as Chairman, will be hostess for tennis. The Marion County Auxiliary will be in the hostess role for a "Futura Fantasy" Dance at 10 P.M. Friday. Mrs. J. T. Mallamo of Fairmont has the Marion County Chairman's responsibility. All physicians, their wives and others registered for the Convention are invited to attend.

Post-Convention Board Meeting

Mrs. Kugel will preside at the Post-Convention Conference and Board Meeting at 10 A.M. on Saturday, August 25, in the Fillmore and Van Buren Rooms.

Saturday Afternoon Agenda

Auxiliary members are invited to attend the second and final session of the Medical Association's House of Delegates on Saturday at 2:30 P.M., at which time Doctor McKinney will deliver his Presidential Address; Dr. A. Thomas McCoy of Charleston will be installed as the Association's President, and other Association officers will be elected.

At 6:30 P.M. on Saturday, there will be a reception on the Chesapeake Hall Terrace honoring officers of the Medical Association. Auxiliary members are cordially invited to attend.

Other Convention Matters

Those Auxiliary members who will participate in bridge and golf activities, as well as tennis, are urged to sign up in advance at the registration desk.

The Auxiliary also will sponsor a Hobby Show in conjunction with the Medical Association's annual offering of scientific and industrial exhibits.

Mrs. Robert G. Janes

Cookbook on Foreign Food Favorites Compiled by Woman's Auxiliary

The Woman's Auxiliary to the West Virginia State Medical Association has compiled a beautiful new cookbook entitled "Foreign Food Favorites."

The cookbook is a unique collection of foreign recipes from Auxiliary members in West Virginia, many of whom are foreign born. The cookbook was taken to the AMA Auxiliary Convention in New York City and will be available for sale at the State Auxiliary Convention at The Greenbrier in White Sulphur Springs, August 22-25.

The cookbooks are a joint project of the International Health and the American Medical Association Education and Research Foundation and all proceeds go to AMA-ERF.

County Auxiliaries will have the books for sale in September. Persons interested in obtaining a copy in advance may do so by sending $4.50 (to cover postage and handling) to: Foreign Food Favorites, Mrs. Robert G. Janes, 1707 Country Club Road, Fairmont, W. Va. 26554.

12 HOURS AAFP CREDIT

The 106th Annual Meeting of the West Virginia State Medical Association has been authorized as acceptable for 12 elective hours credit by the American Academy of Family Physicians.

Grants Offered By Prevention Of Blindness Agency

The National Society for the Prevention of Blindness announces that it has research funds available for pilot projects which do not exceed $5,000 per year. Investigators not currently financed by other sources of research funds are invited to apply.

Acceptable projects are those which may contribute to the prevention of blindness and eye disease through basic studies of eye function and disease, or that may improve diagnosis and treatment.

The National Society for the Prevention of Blindness will accept applications any time during the year and will make awards promptly after evaluation by their Committee on Basic and Clinical Research.

Application forms and further information may be obtained by writing to the Committee on Basic and Clinical Research, National Society for the Prevention of Blindness, Inc., 79 Madison Avenue, New York, N.Y. 10016.

The National Society for the Prevention of Blindness, Inc., founded in 1908, is the oldest voluntary health agency nationally engaged in the prevention of blindness through a comprehensive program of community service, public and professional education and research.

Implementation Of Malpractice Suggestions Program Topic

A postgraduate course, "Symposium—Implementation of the Recommendations of the Secretary's Commission on Malpractice," will be held by the Cleveland Clinic Educational Foundation on September 6. Co-sponsored by the American College of Legal Medicine, discussion will be on proposals implementing the recommendations made by the Commission on Malpractice of the Secretary of the Department of Health, Education and Welfare.

The registration fee for the symposium is $40. The course is acceptable for Category 1 credit toward the AMA Physician's Recognition Award. For further information, contact the Foundation at 9500 Euclid Avenue, Cleveland, Ohio, 44106.

Nephrology Seminar At UK In September

"Nephrology for the Practicing Physician," a two-day seminar, will be held at the University of Kentucky Medical Center September 21 and 22. Program Chairman will be Dr. Robert G. Luke.

The registration fee is $40. Seven hours of AAFP credit have been requested. Following the seminar, the Kentucky Wildcats will meet the Crimson Tide of Alabama in U. K.'s new football stadium.

For further information, contact Ronald D. Hamilton, M. D., Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Aug. 17—Medic Alert Found., Turlock, Calif.
Aug. 19-20—Am. Acad. Med. Administrators, Chicago.
Aug. 20-23—Am. Health Congress, Chicago.
Aug. 22-25—106th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.
Aug. 28-31—Wyo. St. Med. Soc., Jackson Lake Lodge.
Sept. 6-8—Am. Assn. Ob. & Gyn., Hot Springs, Va.
Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 15-16—Am. Assn. Oph., Dallas.
Sept. 16-20—Am. Assn. of Med. Clinics, L. A.
Sept. 16-20—Am. Acad. of Oph. and Otol., Dallas.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 20-23—Am. Soc. Internal Med., Dallas.
Sept. 27-29—Natl. Conf. Cancer of Colon & Rectum, Bal Harbour, Fla.
Sept. 29-30—AMA on Alcoholism, Pocono Manor, Pa.
Oct. 1-4—AAFP, Denver.
Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 7-11—Am. Soc. Anesth., San Francisco.
Oct. 10-13—Pa. Med. Society (Scientific), Harrisburg.
Oct. 15-19—ACS Clinical, Chicago.
Oct. 17-21—Eastern Orthopaedic Assn., White Sulphur Sprgs.
Oct. 18-21—Med. Soc. of Va., Norfolk.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.
Oct. 21-26—Am. Acad. Physical Med. & Rehab., Washington.
Oct. 22-24—Am. Coll. of Gastro., L. A.
Oct. 26-28—Pot.-Shen. PG Institute, Martinsburg.
Oct. 31—Nov. 1—Am. Assn. Study of Liver Diseases, Chicago.
Nov. 4-8—Assn. Am. Med. Colleges, Wash.
Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-12—Am. Assn. Cancer Educat., Honolulu.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.
Nov. 14-17—Am. Acad. of Neuro. Surgery, Pasadena.
Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.

1974

Jan. 18-20—Mid-Winter Clinical Conf., Charleston.
Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.
Jan. 19-24—Am. Acad. Ortho. Surgeons, Dallas.
Feb. 11-14—Am. Coll. Card., N. Y.

CONVENTION PROGRAM

106th Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS
August 22-25, 1973

WEDNESDAY MORNING

August 22

(Eastern Daylight Time)

9:00-5:00—Registration, Main Floor Lobby.

10:00—Pre-Convention Meeting of the Council. Harry S. Weeks, Jr., M.D., *presiding* (Lee Room, Virginia Wing).

WEDNESDAY AFTERNOON

2:30—First Session of the House of Delegates. Worthy W. McKinney, M.D., *presiding* (Chesapeake Hall).

Invocation—Carl B. Hall, M.D.

Address: Russell B. Roth, M.D., President, American Medical Association.

Presentation of AMA-ERF Check to the West Virginia University School of Medicine.

Business Meeting.

WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Chesapeake Hall Terrace).

THURSDAY MORNING

August 23

8:00—Motion Pictures. David Z. Morgan, M.D., *in charge* (Governor's Hall).

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Governor's Hall)

9:00—Call to Order—Worthy W. McKinney, M.D., President, West Virginia State Medical Association.

Invocation—William E. Gilmore, M.D.

Address of Welcome—A. Thomas McCoy, M.D., Chairman of the Program Committee.

"The Thomas L. Harris Address"

Hon. Arch A. Moore, Jr., Governor of the State of West Virginia.

First General Session

"Symposium on New Concepts of The Medical and Surgical Treatment of Coronary Artery Disease"

Moderator: William H. Carter, M.D.

9:45—C. Richard Conti, M.D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore. Subject: "Medical Therapy of Angina Pectoris."

10:15—James J. Morris, Jr., M.D., Associate Professor of Medicine, Duke University School of Medicine, Durham. Subject: "Angiographic and Hemodynamic Aspects of Coronary Artery Disease."

10:45—Recess for Visiting Exhibits.

11:15—William H. Muller, Jr., M.D., Professor and Chairman of the Department of Surgery, University of Virginia School of Medicine, Charlottesville. Subject: "Surgical Aspects of Coronary Artery Disease."

11:45—Question and Answer Period.

12:15—Recess for Lunch and Visiting Exhibits.

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. Harry S. Weeks, Jr., M.D., *presiding* (Tyler Room).

THURSDAY AFTERNOON

2:00—Resolutions Committee. Richard E. Flood, M.D., *presiding* (West Virginia Room).

2:00—Open Meeting on "Matters of Interest to Practicing Physicians and the Internal Revenue Service." Philip M. Sprinkle, M.D., *presiding* (Fillmore and Van Buren Rooms).

Speaker: Mortimer M. Caplin, Senior Partner in the Law Firm of Caplin & Drysdale of Washington, D. C.

3:30—"Seminar on the Causes and Prevention of Malpractice Claims." Carl A. Hoffman, M.D., *presiding* (Tyler Room).

Speakers: David C. Kellsey, M.D., D. John Pecorino, L.LB., and F. M. Taylor, all Staff Members of Aetna Casualty and Surety, Administrator for the Group Liability Insurance Program for the West Virginia State Medical Association.

6:00—Cocktail Party. West Virginia University Alumni Association. Clark K. Sleeth, M.D., *in charge* (Fillmore and Van Buren Rooms).

6:00—Cocktail Party. University of Virginia Alumni Fund, Medical Division. E. L. Crumpacker, M.D., *in charge*.

6:30—Cocktail Party. West Virginia Chapter, Medical College of Virginia Alumni Association. R. S. Birckhead, M.D., *in charge* (Old White Club).

FRIDAY MORNING

August 24

8:00—Breakfast Meeting, W. Va. Academy of Ophthalmology and Otolaryngology (Washington Room, Virginia Wing).

8:00—Motion Pictures. David Z. Morgan, M.D., *in charge* (Governor's Hall).

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderator: C. Richard Daniel, M.D.

9:30—Theodore M. King, M.D., Professor and Director of the Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine, Baltimore. Subject: "Abortifacients—Efficacy and Untoward Effects."

10:15—Alvin L. Watne, M.D., Professor of Surgery, West Virginia University School of Medicine, Morgantown. Subject: "Colon Polyposis and Colon Cancer."

11:00—Recess for Visiting Exhibits.

11:30—John A. Kirkpatrick, Jr., M.D., Professor of Radiology and Pediatrics, Temple University School of Medicine, Philadelphia. Subject: "Respiratory Obstruction in Differential Diagnosis and Diagnostic Techniques."

12:15—Recess for Lunch and Visiting Exhibits.

12:15—Meeting of Cancer Committee (Main Dining Room).

FRIDAY AFTERNOON

2:00—Section on Internal Medicine. Thomas O. Dotson, M. D., *presiding* (Governor's Hall).

Guest Speakers: James J. Morris, Jr., M.D., Durham, North Carolina. Subject: "Survival After an Acute Myocardial Infarction."

C. Richard Conti, M.D., Baltimore, Maryland. Subject: "Unstable Angina."

2:00—Joint Meeting of the West Virginia Radiological Society and the Section on Pediatrics and West Virginia Chapter, American Academy of Pediatrics. Joseph N. Aceto, M.D., and Barbara Jones, M.D., *presiding* (Fillmore and Van Buren Rooms).

Guest Speaker: John A. Kirkpatrick, M.D., Philadelphia. Subject: "Neoplasia and Associated Abnormalities in Infants and Children."

2:00—Section on Surgery. Maynard P. Pride, M.D., *presiding* (Mountaineer Room).

Guest Speaker: William H. Muller, Jr., M.D., Charlottesville, Virginia. Subject: "Thymectomy for Myasthenia Gravis."

2:00—Section on Neurology, Neurosurgery and Psychiatry. Ludwig Gutmann, M.D., *presiding* (Director's Room).

Guest Speaker: Samuel M. Chou, M.D., Professor of Neuropathology at the West Virginia University School of Medicine, Morgantown. Subject: "Slow Viruses and 'Degenerative' Brain Disease."

2:00—Section on Orthopedic Surgery. Robert R. Weiler, M.D., *presiding* (Washington Room, Virginia Wing).

Guest Speaker: John B. Blakley, M.D., Allegheny General Hospital, Pittsburgh. Subject: "Indications for and Results of Anterior Cervical Fusions."

2:00—Section on Urology. Harold N. Kagan, M.D., *presiding* (Jackson Room).

3:00—West Virginia Chapter, American Society of Internal Medicine. Leo H. T. Bernstein, M.D., *presiding* (Governor's Hall).

3:00—West Virginia District Branch, American Psychiatric Association. Thomas S. Knapp, M.D., *presiding* (Director's Room).

3:30—Open Meeting on "Qualifying Evaluation of the Medical Graduate Including the Foreign Graduate—With a Look to the Continuing Evaluation and Re-Certification of Physicians." Richard E. Flood, M.D., and Maynard P. Pride, M.D., *presiding* (West Virginia Room).

Guest Speaker: William A. Sodeman, M.D., Philadelphia, Chairman, AMA Council on Medical Education.

5:00—Committee on Nominations. George R. Callender, Jr., M.D., *presiding* (Lee Room, Virginia Wing).

FRIDAY EVENING

10:00—Dance: "Futura Fantasy" sponsored by the Woman's Auxiliary. Hostess: Marion County Auxiliary—Mrs. J. T. Mallamo, Chairman. (Cheaspeake Hall).

SATURDAY MORNING

August 25

8:00—Motion Pictures. David Z. Morgan, M.D., *in charge* (Governor's Hall).

9:00-2:00—Registration, Main Floor Lobby.

Third General Session

"Symposium on Family Practice"

Moderator: Clark K. Sleeth, M.D.

9:30—Participants:

James L. Grobe, M.D., Phoenix, Arizona, President of the American Academy of Family Physicians.

Richard W. Lindsay, M.D., Chairman of the Department of Family Practice at the University of Virginia School of Medicine.

Dr. Wyn Rhys-Jones, Department of Family Practice at the University of Ottawa and the Ottawa Civic Hospital.

(There Will be a Recess for Visiting Exhibits During the Morning Session).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates. Worthy W. McKinney, M.D., *presiding* (Chesapeake Hall).

Invocation—Joe N. Jarrett, M. D.

Presidential Address: Worthy W. McKinney, M.D., President, West Virginia State Medical Association.

Introduction of President of Woman's Auxiliary to the West Virginia State Medical Association.

Introduction of Honor Guests.

Business Meeting.

Election of Officers.

Installation of A. Thomas McCoy, M.D., of Charleston, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

(Biographical Sketches)

Dr. James J. Morris, Jr., Associate Professor of Medicine and Project Director of The Myocardial Infarction Research Unit at the Duke University Medical Center, is a native of Jersey City, New Jersey.

James J. Morris, Jr., M. D.

He was graduated from Hofstra College and received his M.D. degree in 1959 from the State University of New York, Downstate Medical Center, Brooklyn, New York. He interned at Duke Hospital and served residencies at that hospital and at the Veterans Administration Hospital in Durham.

He served as a member of the faculty at the Duke University Medical Center from 1964 to 1966 and in 1967 he served as Assistant Professor of Medicine at the University of Pennsylvania School of Medicine and as director of the Hemodynamics Laboratories at the University of Pennsylvania Hospital. He was certified by the American Board of Internal Medicine in 1969 and currently is a Teaching Scholar of the American Heart Association.

Dr. John B. Blakley, a member of the Senior Attending Staff at Allegheny General Hospital in Pittsburgh, is a native of Aspinwall, Pennsylvania.

He was graduated from Franklin Marshall College and received his M.D. degree in 1947 from Temple University School of Medicine. He interned at Hamot Hospital in Erie, Pennsylvania, and served residencies in orthopedic surgery at that hospital and at New York State Rehabilitation Hospital in West Haverstraw. He also took additional training in orthopedic surgery at the New York University Postgraduate School. He served for two years as a Lieutenant in charge of the orthopedic service at the U. S. Naval Hospital in Portsmouth, New Hampshire. He has been a member of the staff at Allegheny General Hospital since 1953.

John B. Blakley, M. D.

He was certified by the American Board of Orthopaedic Surgery in 1956 and is a Fellow of the American College of Surgery and the American Academy of Orthopaedic Surgery. He has served since 1964 as secretary-treasurer of the Interstate Orthopaedic Society.

Dr. William A. Sodeman, Executive Director of the Commission on Foreign Medical Graduates with offices in Philadelphia, is a native of Charleroi, Pennsylvania.

He received his M. D. degree in 1931 from the University of Michigan School of Medicine and served his internship at St. Vincent's Hospital in Toledo, Ohio, in 1931-32. From 1932-1940, he served as Instructor in Medicine at Tulane University School of Medicine. He then was named Assistant Professor of Medicine and in 1941 he was appointed Professor and Head of the Department of Preventive Medicine. In 1946 he was appointed Professor and Head of the Department of Preventive Medicine. In 1946 he was named Professor of Tropical Medicine and Chairman of the Department of Tropical Medicine and Public Health.

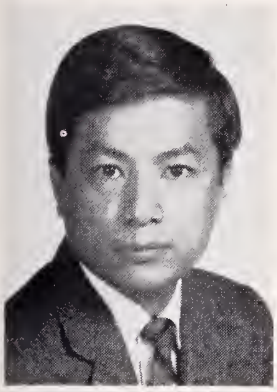
William A. Sodeman, M. D.

He was appointed Professor and Chairman of the Department of Medicine at the Missouri University School of Medicine in 1953. He served in that position until 1957 at which time he accepted appointment as Magee Professor of Medicine and Head of the Department at Jefferson Medical College of Philadelphia. He was named Dean in 1958 and served in that position until his retirement in 1967 at which time he joined the Life Insurance Medical Research Firm as Scientific Director. He was named to his present position on March 1, 1970.

Doctor Sodeman is immediate Past President of the American College of Physicians and is currently serving as Chairman of the Council on Medical Education of the American Medical Association.

Dr. Samuel Chou, Professor of Neuropathology at the West Virginia University School of Medicine, is a native of Tokyo, Japan.

He received his M.D. degree in 1957 from National Taiwain University in Taipei, and served a rotating internship at National Taiwain University Hospital. He served residencies at the Air Force Hospital and at MacKay Hospital in Formosa, and took a combined Ph.D. and residency program in pathology and neuropathology at the University of Wisconsin Hospital. He also served as a Fellow of the National Multiple Sclerosis Society at the University of Wisconsin School of Medicine.



Samuel Chou, M. D.

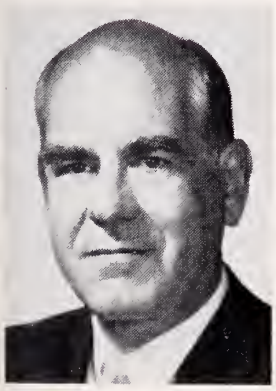
Doctor Chou served as a member of the faculty at the University of Wisconsin School of Medicine from 1965 to 1968, at which time he joined the faculty at the WVU School of Medicine.

He is a member of the American Association for the Advancement of Science, American Association of Neuropathologists and the American Academy of Neurology.

He is the author or co-author of numerous scientific articles which have been published in professional journals.

Dr. Russell B. Roth of Erie, Pennsylvania, who was installed as President of the American Medical Association in New York City in June, is a native of Erie.

Doctor Roth was graduated from Yale University and received his M.D. degree in 1939 from Johns Hopkins University School of Medicine. He interned at Johns Hopkins University Hospital and served residencies at St. Mary's Hospital in Pierre, South Dakota; Henry Ford Hospital in Detroit and the Brady Institute in Baltimore.



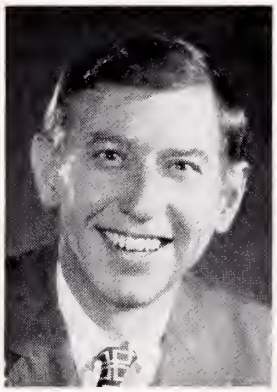
Russell B. Roth, M. D.

He served as a Captain in the Medical Corps of the United States Army during World War II and also served as a member of the Surgeon General's Advisory Committee on the United States National Health Survey, 1961-64, and as a member of the Dependents Medical Care Advisory Committee. He is currently a member of the National Advisory Council for HEW Regional Medical Programs and has been a member of the Special Medical Advisory Group for the Veterans Administration.

Doctor Roth's service to the AMA includes participation in several committees and as Chairman of the Key Council on Medical Service. He was named Vice Speaker of the AMA House of Delegates in 1966 and was serving as Speaker when he was named by acclamation as President Elect in 1972.

Dr. John A. Kirkpatrick, who holds the positions of both Professor of Radiology and Professor in Pediatrics at the Temple University School of Medicine, is a native of Waynesboro, Pennsylvania.

He was graduated from Franklin and Marshall College and received his M.D. degree in 1949 from the Temple University School of Medicine. He interned at York Hospital in York, Pennsylvania, and served residencies at Temple University Hospital and Children's Medical Center in Boston. He served as a Lieutenant in the Medical Corps of the United States Navy, 1950-52, and was a medical officer at the U.S. Naval Academy in Annapolis, Maryland.



John A. Kirkpatrick, M. D.

He has been a member of the faculty at the Temple University School of Medicine since 1956 and is a radiologist at St. Christopher's Hospital for Children and the Childrens Heart Hospital. He also is a consultant in radiology at a number of hospitals in the Philadelphia area. He was certified by the American Board of Radiology in 1956 and has served as an examiner for the board for the past three years.

He is a Past President of the Society for Pediatric Radiology and a member of the Radiological Society of North America, American College of Radiology and the American Roentgen Ray Society. He also is an Affiliate Fellow of the American Academy of Pediatrics.

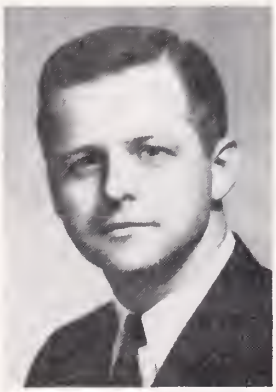
Dr. Theodore M. King, Professor and Director of the Department of Gynecology and Obstetrics at Johns Hopkins University School of Medicine, is a native of Quincy, Illinois. He was graduated from Quincy College, received a Master's Degree in zoology from the University of Illinois, and a Ph.D. Degree in physiology from Michigan State University. He received his M. D. Degree in 1959 from the University of Illinois School of Medicine.

Theodore M. King, M. D.

He interned at the Presbyterian - Columbia Medical Center in New York City and served a residency at the Sloan Hospital for Women in New York City. He served as a member of the faculty at the University of Missouri School of Medicine, 1965-68, and was Professor and Chairman of the Department of Obstetrics and Gynecology at the Albany Medical College of Union University in Albany, New York, 1968-71. He was named to his present position in November, 1971.

He was certified by the American Board of Obstetrics and Gynecology in 1967 and is a member of the American College of Surgery and the American College of Obstetricians and Gynecologists. He also is a member of the Association of Professors of Gynecology and Obstetrics and is Gynecologist-Obstetrician-in-Chief at the Johns Hopkins Hospital in Baltimore.

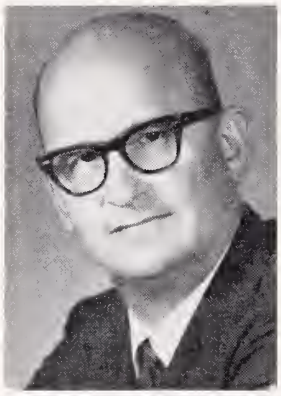
Dr. C. Richard Conti, a native of Allentown, Pennsylvania, is Associate Professor of Medicine at the Johns Hopkins University School of Medicine and serves as Medical Director of the Cardiovascular Diagnostic Laboratory and Wellcome Research Laboratory at that institution.


C. Richard Conti, M. D.

He was graduated magna cum laude from Lehigh University and received his M. D. Degree in 1960 from the Johns Hopkins University School of Medicine. He interned and served a residency at the Johns Hopkins Hospital and was Chief Resident of the Osler Medical Service at that Hospital, 1967-68. He has been a member of the faculty at Johns Hopkins since 1968 and also serves as Visiting Physician at Good Samaritan Hospital and Baltimore City Hospitals.

He served as a Captain in the Medical Corps of the United States Air Force, 1962-64, and was certified by the American Board of Internal Medicine in 1967. He also is a member of the Subspecialty Board on Cardiovascular Disease and a member of Phi Beta Kappa, Alpha Omega Alpha, American College of Physicians and the American College of Cardiology.

Dr. William H. Muller, Jr., Professor and Chairman of the Department of Surgery at the University of Virginia School of Medicine in Charlottesville, is a native of Dillon, South Carolina. He was graduated from the Citadel and received his M.D. degree in 1943 from the Duke University School of Medicine. He interned and served residencies at the Johns Hopkins Hospital in Baltimore and served as a Captain in the Medical Corps of the United States Army from 1946 to 1947. He was engaged in the private practice of general surgery for one year at Dillon, South Carolina.

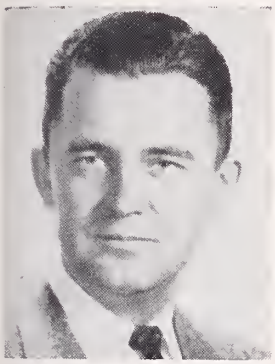

William H. Muller, Jr., M.D.

Doctor Muller was a member of the faculty at the Johns Hopkins Hospital for one year before joining the faculty at the University of California at Los Angeles School of Medicine. He remained there from 1949 until 1954 when he accepted his present position at the University of Virginia.

He is a Diplomate of both the American Boards of Surgery and Thoracic Surgery and is a Regent of the American College of Surgeons. He served for a year as Vice Chairman of the American Board of Surgery and is a Past President of the Society of University Surgeons. He has served since 1959 as a member of the Advisory Council to The Greenbrier Clinic and served for five years as Editor of the *Transactions of the American Surgical Association*. He also served as a member of the Editorial Board of the *Virginia Medical Monthly* from 1958 to 1965 and he is a member of the Editorial Boards of several other national surgical journals.

Dr. Alvin L. Watne, Professor of Surgery at the West Virginia University School of Medicine, is a native of Shabbona, Illinois.

He was graduated from the University of Illinois and received his M.D. degree in 1952 from the University of Illinois College of Medicine. He also received an M.S. degree in surgery in 1956 from the University of Illinois Graduate School of Medicine. He interned at Indianapolis General Hospital and served a residency at the University of Illinois Research and Education Hospital.



Alvin L. Watne, M. D.

Prior to joining the faculty at the WVU School of Medicine, Doctor Watne was Associate Chief Cancer Research Surgeon at Roswell Park Memorial Institute in Buffalo, New York. In addition to his duties as Professor of Surgery, Doctor Watne occupies the Charleston Foundation Chair of Cancer Research at the WVU School of Medicine.

A Diplomate of the American Board of Surgery, Doctor Watne served during the past year as President of the West Virginia Chapter of the American College of Surgeons. He also is currently serving as Chairman of the Cancer Committee of the State Medical Association.

Dr. James L. Grobe, a native of Huntington, West Virginia, was graduated from Marshall University and attended the two-year West Virginia University School of Medicine. He received his M.D. degree in 1952 from the Medical College of Virginia and served an internship at Good Samaritan Hospital in Phoenix, Arizona.

James L. Grobe, M. D.

He has been in a three-man family practice partnership at the Kalor Medical Clinic in Phoenix since 1953 and has been active in the Arizona Chapter of the AAFP and the Arizona Medical Association since that time. He is a Past President of both organizations.

He served as a member of the Congress of Delegates of the AAFP from 1961 to 1968, at which time he was elected to the Board of Trustees. He served as Chairman of the Board for two years prior to being named President Elect of the organization.

He is Immediate Past President of the Arizona Blue Shield, President of the Western Conference of Prepaid Medical Plans and a member of the Council on Mental Health of the American Medical Association.

In 1966, he was the recipient of an award from the Arizona Psychiatric Association for outstanding contributions to the field of psychiatry.

Mortimer M. Caplin, Senior Partner in the Law Firm of Caplin & Drysdale of Washington, D. C., was graduated from the University of Virginia and received his LL.B. degree in 1940 from the University of Virginia Law School.

Mortimer M. Caplin

He practiced law in New York City from 1941 to 1950 — with time out for military service in the U.S. Navy. During the Normandy Invasion he served as a Navy Beachmaster.

In 1950, Mr. Caplin returned to the University of Virginia to become a Professor of Law, specializing in tax and corporate law. He also continued in practice as a member of a Virginia law firm.

In 1960, following the election of President John F. Kennedy, Mr. Caplin served on the President's Tax Force on Taxation. In January 1961, President Kennedy appointed him U. S. Commissioner of Internal Revenue. He served in that post until July 1964 when he resigned to resume private law practice in Washington with his present firm.

On leaving government service, Mr. Caplin received the Alexander Hamilton Award, the highest award conferred by the Secretary of the Treasury for "outstanding and unusual leadership during service as U. S. Commissioner of Internal Revenue."

Dr. Wyn Rhys-Jones, a native of Stirling, Scotland, was graduated from Llandovery College in West Wales and received his medical degree in 1959 from Trinity College in Dublin. He also received a degree in public health from the University of Toronto in Canada in 1967.

Dr. Wyn Rhys-Jones

He served as a house surgeon at the Royal Gwent Hospital and St. Wollos Hospital in the United Kingdom. He also interned and served a residency at Grace Hospital in Winnipeg, Manitoba, Canada and from 1961 to 1968 he served as a medical officer with the Department of National Health and Welfare. Since 1969 he has served as a member of the staff of the Family Practice Unit at the University of Ottawa—Ottawa Civic Hospital and as a major part-time Assistant Professor in the Department of Epidemiology and Community Medicine at the University of Ottawa.

Doctor Rhys-Jones is currently serving as President of the Ottawa Regional Chapter of the College of Family Physicians of Canada and is a member of the Society of Teachers of Family Medicine. He also is a member of the Ontario Medical Association, Canadian Medical Association and the Primary Care Research Group of North America.

Dr. Richard W. Lindsay is Chairman of the Department of Family Practice at the University of Virginia School of Medicine. He was graduated from Cornell University and received his M.D. degree in 1960 from New York Medical College. He interned at Buffalo General Hospital in Buffalo, New York, and served a fellowship in internal medicine at the University of Virginia Hospital, 1961-62. He was engaged in general practice for a short time in Old Forge, New York.

Richard W. Lindsay, M. D.

He returned to the University of Virginia Hospital in 1962 and served a residency in internal medicine at that Hospital until 1966. He served from 1967 to 1969 as a Major in the Medical Corps of the United States Army.

Doctor Lindsay returned to the faculty at the University of Virginia in 1969 and served as Assistant Dean for two years before accepting his present position. He is a member of the Albemarle County Medical Society, Alpha Omega Alpha and the Society of Teachers of Family Medicine. In 1971 he was named Traveling Fellow of the Royal Society of Medicine and investigated teaching in ambulatory clinics in England.

Gov. Arch A. Moore, Jr., who will deliver the first "Thomas L. Harris Address," is a native of Moundsville and was educated in the public schools of Marshall County. He was graduated from West Virginia University and received his LL.B. degree in 1951.

Gov. Arch A. Moore, Jr.

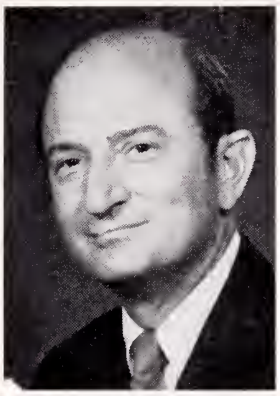
During World War II, Governor Moore served as a Combat Sergeant in the United States Army. He was the recipient of the Purple Heart as the result of severe wounds received on the battlefield.

Governor Moore was elected to the West Virginia House of Delegates in 1952 and in 1956 he was elected to the first of six consecutive terms in the United States Congress. During his service in Congress he became a ranking Republican member of the House Judiciary Committee and several other influential committees.

He was elected the 28th Governor of West Virginia on November 5, 1968, and was inaugurated on January 15, 1969. In the 1972 General Election, he became the first West Virginia Governor to successfully succeed himself in office for another four-year term.

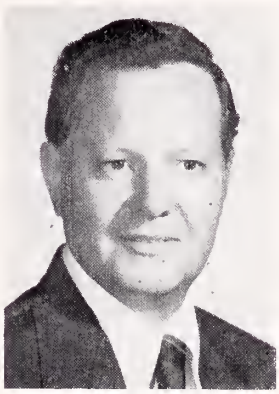
Governor Moore is married to the former Shelley Riley and they have three children.

1973 PROGRAM COMMITTEE

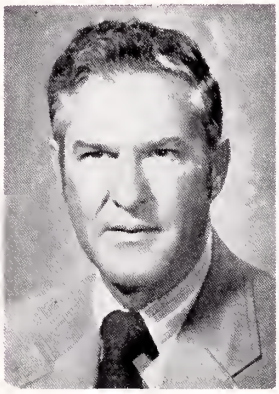


A. Thomas McCoy
Charleston
Chairman

William H. Carter
Charleston



C. Richard Daniel
Beckley



Robert G. Janes
Fairmont

Philip M. Sprinkle
Morgantown

J. Hugh Wiley
Morgantown

DELEGATES AND ALTERNATES

BOONE (2)—Delegates, W. V. Wilkerson, Whitesville; and Harold H. Howell, Madison.

BROOKE (2)—Delegates, John W. Traubert, Wellsburg; and James E. Wise, Follansbee. Alternates, W. T. Booher, Jr., Wellsburg; and Ralph McGraw, Follansbee.

CABELL (10)—Delegates, Gilbert A. Radcliff, M. Bruce Martin, Winfield C. John, Joseph E. Ricketts, Jack Leckie, William L. Neal, C. A. Hoffman, James S. Klumpp, Thomas F. Scott and Charles H. McKown, Jr., Huntington. Alternates, John J. Brandabur, Chesapeake, Ohio; Florence K. Hoback, Ray M. Bobbitt, Charles M. Polan, Salvador Diaz, Wilson P. Smith and Edwin J. Humphrey, III, Huntington; H. S. Mullens and W. W. Mills, Kenova; and William S. Sadler, Barboursville.

CENTRAL WEST VIRGINIA (3) — Delegates, Joseph B. Reed, Buckhannon; Louis W. Groves, Jr., and Clemente Diaz, Richwood. Alternates, Richard A. Bracco and C. R. Davisson, Weston; and R. L. Chamberlain, Buckhannon.

EASTERN PANHANDLE (4)—Delegates, Jean P. Lucas, Leo H. T. Bernstein, C. Vincent Townsend, Martinsburg; and Hiram Sizemore, Jr., Shepherdstown. Alternates, D. Ewell Hendricks, William R. McCune, Martinsburg; Halvard Wanger, Shepherdstown; and Robert R. Pittman, Martinsburg.

FAYETTE (2)—Delegates, Ivan H. Bush, Jr., and Joe N. Jarrett, Oak Hill. Alternates, W. P. Bittinger and J. B. Thompson, Oak Hill.

GREENBRIER VALLEY (3)—Delegates, John J. Yaeger, Herbert L. Pope and Harvey A. Martin, White Sulphur Springs. Alternates, Edward L. Crumpacker, Eugene J. Morhous and H. Charles Ballou, White Sulphur Springs.

HANCOCK (3)—Delegates, J. L. Thompson, Richard E. Flood and Dominic A. Brancazio, Weirton. Alternate, Ray S. Greco, Weirton.

HARRISON (5)—Delegates, Robert D. Hess, Bridgeport; Julian D. Gasataya, Lumberport; M. V. Kalaycioglu, Shinnston; and J. D. H. Wilson, Clarksburg. Alternates, L. Dale Simmons, Herman Fischer, Charles S. Harrison and Paul E. Gordon, Clarksburg.

KANAWHA (16)—Delegates, R. S. Birckhead, Gauley Bridge; William H. Carter, Dominic J. Gaziano, Robert L. Ghiz, Carl B. Hall and George V. Hamrick, Charleston; George W. Hogshead, Nitro; J. Dennis Kugel, Robert L. Leadbetter, Jimmie L. Mangus, John B. Markey, Seigle W. Parks, Carl J. Roncaglione and George A. Shawkey, Charleston; Joseph A. Smith, Dunbar; and Pat A. Tuckwiller, Charleston. Alternates, Arthur A. Abplanalp, Charleston; John S. Blagg, South Charleston; Alberto G. Capinpin, W. A. Cracraft, Thomas J. Janicki, Marcel G. Lambrechts, Mary Lou Lewis, Arthur C. Litton, Daniel A. Mairs, W. O. McMillan, Jr., Robert E. O'Connor, Herbert H. Pomerance and Jack Pushkin, Charleston; Richard C. Rashid, South Charleston; and Harold Selinger and Rodolfo K. Stock, Charleston.

LOGAN (4)—Delegates, Thomas P. Long and Jorge J. San Pedro, Man; and Ray M. Kessel and Abraham Tow, Logan. Alternates, Carlos E. Camargo, Man; and George R. Mullins, Logan.

MARION (4)—Delegates, Joseph D. Romino, Fairmont; Robert R. Frye, Mannington; and William T. Lawson and John C. Turner, Fairmont. Alternates, G. Thomas Evans, John L. Coyner, Mack I. McClain and Robert G. Janes, Fairmont.

MARSHALL (3) — Delegates, E. Y. Baysal, Moundsville; and Kenneth J. Allen, Glen Dale. Alternates, David L. Ealy and William Paul Bradford, Moundsville.

MASON (2)—Delegates, Aarom Boonsue and Antonio G. Sola, Pt. Pleasant. Alternates, Pedro J. Obregon and John M. Grubb, Pt. Pleasant.

McDOWELL (3)—Arthur A. Carr and Emilio Delgado, Welch; and J. H. Murray, Gary. Alternates, D. Castrodale, Ray E. Burger and Richard O. Gale, Welch.

MERCER (5) — Delegates, David F. Bell, Jr., Bluefield; L. J. Pace, Princeton; Sam Milchin, Bluefield, Virginia; Frank J. Holroyd, Princeton; and John J. Mahood, Bluefield. Alternates, Henry F. Warden, Jr., Upshur Higginbotham, Richard O. Rogers, Jr., and J. Elliott Blaydes, Jr., Bluefield.

MINGO (3)—Delegates, Charles H. Bruce, Arthur E. Levy and Paul E. Walker, Williamson. Alternates, Rodrigo V. de Valle and Robert J. Tchou, Williamson.

MONONGALIA (5)—Delegates, David Z. Morgan, Lawrance S. Miller, Thomas M. Howes, Barbara Jones and Isaiah A. Wiles, Morgantown. Alternates, C. A. Logue, John L. Fullmer, J. D. Martin, George Curry and Margaret I. Stemple, Morgantown.

OHIO (8)—Delegates, J. N. Aceto, W. E. McNamara, Robert J. Reed, III, M. D. Reiter, Thomas L. Thomas, Stephen D. Ward, Harry S. Weeks, Jr., and Robert R. Weiler, Wheeling. Alternates, Camilla K. Bauer, W. E. Ackermann, Alfred D. Ghaphery, Fernando G. Giustini, John P. Griffith, Jr., Donald H. Hofreuter, John W. Kennard and Jess S. Renedo, Wheeling.

PARKERSBURG ACADEMY (7)—Delegates, R. J. Bailey, James M. Carter, Richard W. Corbitt, S. William Goff, Lyle D. Vincent, Susan S. Gustke and Paul G. Modie, Jr., Parkersburg. Alternates, Dwight P. Cruikshank, Frederick D. Gillespie, Fay P.

Greene, Jr., John E. Beane, F. Lloyd Blair, Asel P. Hatfield and Jose M. Talavera, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Carl A. Liebig, Keyser; Robert W. Bess, Jr., Piedmont; and Esteban Friera, Romney. Alternates, Charles J. Sites, Franklin; Dewey F. Bensenhaver and M. R. Santiago, Jr., Grantsville.

PRESTON (2)—Delegates, Donald P. Brown, Kingwood; and Jerome C. Arnett, Rowlesburg. Alternates, Del Roy R. Davis, Kingwood; and William H. Harriman, Jr., Terra Alta.

RALEIGH (6)—Delegates, Roy James Yates, Walter E. Klingensmith, W. H. Rardin, Richard G. Starr and C. Richard Daniel, Beckley. Alternates, Charles W. Nelson, Jr., Grover C. Hedrick, Jr., James A. Barnes, Robert P. Pulliam and John M. Daniel, Beckley.

SUMMERS (2)—Delegates, P. B. Camara and J. W. Stokes, Hinton. Alternates, Buford W. McNeer, Hinton.

TYGART'S VALLEY (4)—Delegates, A. Kyle Bush and T. H. Chang, Philippi; and P. C. Tampoya, Grafton. Alternates, Hu C. Myers, Philippi; and L. H. Nefflen, Elkins.

WETZEL (2)—Delegates, Charles P. Watson and Lemoyne Coffield, New Martinsville. Alternates, Allen M. Dyer, Jr., Pine Grove; and Terrell Coffield, New Martinsville.

WYOMING (2)—Delegates, Ross E. Newman and George F. Fordham, Mullens.

Reception Committee

JAMES S. KLUMPP, *Chairman*

C. A. Hoffman
Richard E. Flood
Frank J. Holroyd
George R. Callender, Jr.
Harry S. Weeks, Jr.
Jerrill D. Cavender

James T. Hughes
Robert D. Hess
Alvin L. Watne
J. D. Harrah
David B. Gray
A. J. Villani

Carl B. Hall
Donald P. Brown
Richard G. Starr
Philip M. Sprinkle
William C. Morgan, Jr.
J. Hugh Wiley

John J. Battaglino, Jr.
Robert P. Pulliam
John T. Chambers
C. Richard Daniel
Barbara Jones
Joseph N. Aceto

Stephen D. Ward
John M. Hartman
Robert G. Shirey
L. Dale Simmons
Jack Leckie
Maynard P. Pride

Andrew W. Goodwin, II
Joseph B. Reed
Clark K. Sleeth
Joe N. Jarrett
Robert G. Janes
Kenneth G. MacDonald

Richard V. Lynch, Jr.
Thomas O. Dotson
Edmund B. Flink
Upshur Higginbotham
Winfield C. John
William H. Carter

Seigle W. Parks
William E. Gilmore
Richard W. Corbitt
J. C. Huffman
L. J. Pace
George F. Evans

Official Program
WOMAN'S AUXILIARY
to the
West Virginia State Medical Association
49th Annual Meeting
THE GREENBRIER
White Sulphur Springs
August 22-25, 1973

WEDNESDAY AFTERNOON
August 22

2:30—First Session of the House of Delegates, State Medical Association (Chesapeake Hall).

Address by Dr. Russell B. Roth, President, American Medical Association.

4:00—Pre-Convention Board Meeting, Mrs. Robert G. Janes, President, *presiding* (Fillmore-Van Buren Rooms).

WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Chesapeake Hall Terrace).

THURSDAY MORNING
August 23

9:00—Formal Opening of the 106th Annual Meeting of the West Virginia State Medical Association (Governor's Hall).

"The Thomas L. Harris Address"

Hon. Arch A. Moore, Jr., Governor of West Virginia.

(Auxiliary members are invited to attend).

9:45—Formal Opening of the Convention, Mrs. Robert G. Janes, President, *presiding* (Fillmore and Van Buren Rooms).

Invocation—Mrs. Claude R. Davisson.

Memorial—Mrs. Claude Davisson.

Introduction of Honor Guests.

Presentation of Worthy W. McKinney, M.D., President of the West Virginia State Medical Association.

Introduction of Convention Co-Chairmen—Mrs. Kenneth D. Bailey, Mrs. Harry Fleming and Mrs. Charles S. Harrison.

Roll Call of Delegates—Mrs. J. E. Blaydes, Jr.

Convention Rules of Order—Mrs. William T. Lawson.

Treasurer's Report—Mrs. J. L. Mangus.

Credentials and Registration—Mrs. Robert J. Reed III.

Keynote Address—Mrs. Willard C. Scrivner, President, Woman's Auxiliary to the American Medical Association.

Recommendations from the Pre-Convention Board Meeting—Mrs. Robert G. Janes.

New Business and Announcements.

Report of the Nominating Committee, First Reading—Mrs. M. Bruce Martin.

Election of the 1974 Nominating Committee.

Reports of Officers and Standing Committee Chairmen (These reports will not be read, but are published in the Annual Reports Book).

Presentation of Component Auxiliary Presidents by the Regional Directors:

Eastern Region—Mrs. Thomas M. Howes.
Western Region—Mrs. Thomas P. Long.
Northern Region—Mrs. Louis Groves.
Southern Region—Mrs. Richard G. Starr.

Recess.

THURSDAY AFTERNOON

2:00—Bridge (Trellis Lobby), Hostess, Cabell County, Mrs. A. C. Esposito, Chairman.

Exhibit Hall open until 3:30 P.M.

FRIDAY MORNING
August 24

8:00—Past President's Breakfast—Mrs. M. Bruce Martin, Immediate Past President, *presiding* (Virginia Room).

9:45—Second General Session—Mrs. Robert G. Janes, President, *presiding*.

Introduction of Honor Guests.

Roll Call of Delegates—Mrs. J. E. Blaydes, Jr.

Report of Reading Committee—Mrs. William Welton.

Reports of Convention Committees:

Finance—Mrs. Charles E. Andrews.

Credentials and Registration—Mrs. Robert J. Reed III.

Press and Publicity—Mrs. John E. McKenzie.

Presentation of AMA-ERF Awards.

Acting Dean John E. Jones, West Virginia University School of Medicine; Mrs. Robert R. Weiler, State Chairman; and Mrs. William J. Reardon, Eastern Regional AMA-ERF Chairman.

Address—Mrs. Erle E. Wilkinson, President of the Woman's Auxiliary to the Southern Medical Association.

Unfinished Business.

Report of Nominating Committee, Second Reading—Mrs. M. Bruce Martin.

Election of Officers.

Installation of Officers—Mrs. Willard C. Scrivner, President, Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel—Mrs. Robert G. Janes.

Presentation of Past President's Pin—Mrs. M. Bruce Martin.

Inaugural Address—Mrs. J. Dennis Kugel.

Announcements.

Adjournment.

FRIDAY AFTERNOON

Golf—Hostess, Central West Virginia, Mrs. Louis Groves, Chairman.

Tennis—Hostess, Mercer County, Mrs. J. E. Blaydes, Jr., Chairman.

Visit The Hobby Show and Exhibits. Exhibit Hall Open Until 3:30 P.M.

FRIDAY EVENING

10:00—Dance—"Futura Fantasy"—Hostess, Marion County, Mrs. J. T. Mallamo, Chairman (Chesapeake Hall).

SATURDAY MORNING

August 25

10:00—Post-Convention Conference and Board Meeting—Mrs. J. Dennis Kugel, President, *presiding* (Fillmore and Van Buren Rooms).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates of the State Medical Association (Chesapeake Hall).

Presidential Address—Worthy W. McKinney, M.D.

Installation of A. Thomas McCoy, M.D., as 1973-1974 President of the West Virginia State Medical Association.

(Auxiliary Members are invited to attend).

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

SCIENTIFIC EXHIBITS

ARGON LASER PHOTOCOAGULATOR

The Argon Laser has been adapted for photocoagulation inside the eye. Shown are "before" and "after" pictures of its results in treatment of diabetic retinopathy. If treated at the right time diabetic retinopathy progression can be slowed. A National Cooperative Study of diabetics is being conducted to determine the optimal time for photocoagulation of diabetic retinopathy. Argon laser photocoagulation is being accomplished in West Virginia at the Eye and Ear Clinic of Charleston. Those patients who qualify for the national study are referred to Johns Hopkins.

Robert E. O'Connor, M. D.

AMERICAN ASSOCIATION OF OPHTHALMOLOGY

All persons in attendance at the Annual Meeting are invited to undergo eye screening tests on a first come-first served basis. Screening tests will be visual acuity at distance and near, phorias, color vision, fusion and stereoscopy, visual fields and intraocular tension, all done in a matter of minutes. Instruments used will be a Titmus Sight Screener with special slides and recording forms, a Harrington visual field screener, and an American Optical non-contact tonometer.

Ralph W. Ryan, M.D.

AMERICAN CANCER SOCIETY
West Virginia Division, Inc.

1. "PITFALLS IN CANCER MANAGEMENT."
2. "PROCTO-SIGMOIDOSCOPY MODEL." The first exhibit brings out the fact that physicians can avoid pitfalls in cancer management by taking adequate histories, doing complete physical examinations, and being constantly alert for cancer with all patients, asymptomatic as well as symptomatic. The second exhibit is a Procto-Sigmoidoscopy model which will be manned by physicians showing the techniques involved in performing a Procto-Sigmoidoscopy examination.

Tim Bradford, Division Program Director.

AMERICAN GERIATRICS SOCIETY, INC.

"ADEQUATE MEDICAL CARE FOR THE AGED." There are 21 million Americans aged 65 or over (increasing by 1,000 persons every 24 hours). Aging people are afflicted with special mental and physical health problems. Insufficient numbers of health professionals are trained in Geriatrics. Research is needed to make the increasing life span of man both productive and enjoyable, thereby assuring the right of the aged to live in dignity.

F. P. Rhoades, M.D., Chairman of the Board of Trustees; and N. A. Rhoades, Technician.

THE MYERS CLINIC—BROADDUS HOSPITAL

"PATHOPHYSIOLOGY AND MANAGEMENT OF TRAUMATIC SHOCK." The purpose of this exhibit presents the management of patients in shock and also the teaching methods used in the presentation of this material to surgical residents and physician's assistant students. Eleven illustrations, designed and drawn by the author, are presented to show the pathophysiology and management of shock. Specific changes occurring in the heart, brain, kidneys, liver and lungs in low flow state are illustrated and various points in management demonstrated. The relationship between pH, bicarbonate and PCO_2 in our major acid base disturbances and eight other disturbances of neutrality regulation are demonstrated.

T. H. Chang, M. D., and J. Richard Crawford.

THE NATIONAL FOUNDATION MARCH OF DIMES

"NUTRITION AND PREGNANCY." This exhibit displays proper nutrition which is necessary for the good health of the mother and her baby during pregnancy.

G. William Trout, West Virginia Field Representative.

NATIONWIDE INSURANCE COMPANY

"PART B CARRIER'S ROLE IN MEDICARE." Part B Carrier's role in Medicare is briefly described in the display. The booth will be in charge of Mr. R. E. Lenhart, Medicare Manager of West Virginia. Other experienced Nationwide Medicare personnel will be available to answer questions regarding Nationwide's new electronic data processing system which began operation in December, 1972. The Field Operations staff also will be prepared to answer questions relating to the new 1972 amendments which now encompass the disabled and broaden Medicare coverage.

R. E. Lenhart, Medicare Manager, West Virginia; Donald F. Harper and Randall S. Swecker, District Medicare managers, and Hugh F. Hughes, Field Operations Manager.

STATE COMPREHENSIVE HEALTH PLANNING AGENCY

"COMPREHENSIVE HEALTH PLANNING." This exhibit will offer materials and information about the development of Comprehensive Health Planning in the United States, in West Virginia and in each of the 11 regions of the State. Staff members from the Agency and others knowledgable about the subject will be at the exhibit at all times to answer questions and receive suggestions. Every physician will have the opportunity to be informed about the new responsibilities assigned to Comprehensive Health Planning agencies by Federal legislation.

Harry A. Stansbury, Jr., Ph.D., State Director.

THE AMERICAN COLLEGE OF RADIOLOGY AND THE NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

"RADIOLOGICAL DESCRIPTION OF COAL WORKERS' PNEUMOCONIOSES." The exhibit recapitulates the UICC/Cincinnati Classification of the Radiographic Appearances of the Pneumoconioses and shows the film quality required for demonstrating parenchymal lesions in the lungs.

Daryl A. Walker, Assistant Conference Coordinator.

WEST VIRGINIA DEPARTMENT OF AGRICULTURE, POULTRY DEVELOPMENT SECTION; WEST VIRGINIA POULTRY ASSOCIATION, AND THE AMERICAN EGG BOARD

"CHOLESTEROL AND HEALTH." This exhibit presents information and review material on the status of cholesterol in human nutrition.

Charles Fox, Chief, Poultry Development Section, West Virginia Department of Agriculture.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH, DIVISION OF MATERNAL AND CHILD HEALTH DEMONSTRATION PROJECT; AND THE WEST VIRGINIA INTERAGENCY COUNCIL

"THE EARLY CHILDHOOD DEVELOPMENT PROGRAM." This program has as its basic philosophy the right of every child born in West Virginia to be born whole and well, to be wanted, to have continuing care, and to develop his full potential. In order to achieve this goal complete health services for mothers from conception and children to age six are offered the medically indigent in eight counties. The exhibit explains how these health services are delivered.

N. H. Dyer, M.D., M.P.H., State Director of Health; and Henrietta L. Marquis, M.D., Pediatric Consultant.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

"MANPOWER IN MENTAL HEALTH." The past, present and future of manpower in mental health will be featured. "Light the Way for Mental Health" will be a sub-feature, as will "Child's Bill of Rights." A Department of Mental Health progress brochure will be available.

Blaine P. Dowler, Coordinator; James R. Clowser, Deputy Director, and Mildred Mitchell-Bateman, M.D., Director.

WEST VIRGINIA HEART ASSOCIATION

"HEART ASSOCIATION PROGRAMS AND YOU." Test your skill in delivering cardiopulmonary resuscitation on the new Recording Resusci-Anne at the Exhibit. Also on display will be new publications and the materials and equipment being used in the blood pressure screening programs conducted throughout West Virginia by the Association.

Virginia Harris, Program Director; and Darrell Torman, Field Representative.

WEST VIRGINIA TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION, INC.

"THE PATHOLOGY OF COAL WORKERS' PNEUMOCONIOSIS." The exhibit illustrates the project of the pathology section of the Appalachian Laboratory for Occupational Respiratory Diseases (ALFORD), U. S. Public Health Service, Morgantown.

Melvin H. Lively, Acting Director.

WEST VIRGINIA DEPARTMENT OF WELFARE; WEST VIRGINIA WORKMEN'S COMPENSATION FUND; WEST VIRGINIA DIVISION OF VOCATIONAL REHABILITATION, AND DISABILITY DETERMINATION SECTION, U.S. SOCIAL SECURITY ADMINISTRATION.

"DISABILITY EVALUATION: A MUTUAL INVESTMENT." Four agencies who depend on disability evaluations for determining eligibility and/or for providing services have collaborated in an exhibit illustrating the disability evaluation as a mutual investment. The taxpayer invests his tax dollar in the purchasing of the disability evaluation and the physician invests his time and skills. A quality disability evaluation is vital. A decision can be no better than the information on which it is based. An evaluation which lacks information on certain key issues is a waste of time. A good evaluation is a good investment. The four agencies illustrate what their particular needs are in a disability evaluation.

Leslie McCoy, M.D., Director, Medical Services, West Virginia Division of Vocational Rehabilitation; William S. Herold, M.D., Chief Medical Consultant, Disability Determination Section, U. S. Social Security Administration; John Farley, Assistant Director of Medical Division, West Virginia Workmen's Compensation Fund, and Charles Dawkins, Administrative Assistant, West Virginia Department of Welfare.

WVU SCHOOL OF MEDICINE & ALUMNI ASSOCIATION

"ALUMNI FOLLOW-UP AND PHYSICIAN RECRUITMENT IN WEST VIRGINIA." This updated exhibit will show the names, years of graduation and practice locations in West Virginia of alumni who were graduated after the expansion at WVU to a four-year School of Medicine. Activities of the Headquarters Office of the West Virginia State Medical Association in physician recruitment will be shown as they are coordinated with joint efforts of the Office of the Dean and the School of Medicine's Alumni Association to keep graduates in touch with each other, and with the School.

David Z. Morgan, M. D., Associate Dean; Clark K. Sleeth, M. D., and Ludwig Gutmann, M. D.

WEST VIRGINIA DEPARTMENT OF WELFARE

"DEPARTMENT OF WELFARE MEDICAL PROGRAMS." The Department's exhibit this year will provide information material related to the West Virginia Medicaid and Crippled Children's Services programs. The exhibit will identify eligibility criteria for both programs and list services covered by the Department's programs. New programs to have begun in July, or later in the fiscal year 1973-74, will be illustrated and explained.

Department of Welfare representatives.

INDUSTRIAL EXHIBITS

WILLIAM P. POYTHRESS & COMPANY, INC.
Richmond, Virginia

Booth 2

You are cordially invited to visit the exhibit of Wm. P. Poythress & Company, Inc., manufacturers of ethical pharmaceuticals since 1856. Our medical representative will be available to supply you with literature, samples and technical information on Antrocol, Bensulfoid Lotion, the Mudranes, Panalgesic, Solfo-Serpine, Solfoton, Synirin, Trocinate and Uro-Phosphate.

MEDFACT FILMS
Massillon, Ohio

Booth 7

A. H. ROBINS COMPANY
Richmond, Virginia

Booth 9

You are cordially invited to visit the A. H. Robins exhibit and meet our representatives who will welcome the opportunity to discuss products of interest with you.

Representatives: Gus N. Addington, Jr. and Charles S. Allanson.

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 12, where we are featuring Mellaril, Hydergine and Fiogesic.

AYERST LABORATORIES
New York, New York

Booth 13

Our representatives look forward to a visit with you, and for the opportunity to discuss the Ayerst products and services of interest to you.

Representatives: John Hymen and Don Knight.

CIBA PHARMACEUTICAL PRODUCTS, INC.
Summit, New Jersey

Booth 14

RIKER LABORATORIES, INC.
Northridge, California

Booth 16

You are cordially invited to visit the Riker Laboratories exhibit where our representatives welcome the opportunity to discuss our products with you.

Representatives: Donald Hoover and Bill Williams.

ALERT MEDICAL-SURGICAL CORP.
Charleston, West Virginia

Booth 17

SCHERING LABORATORIES
Kenilworth, New Jersey

Booth 20

Schering Laboratories' exhibit located at Booth No. 20, features Garamycin® Injectable, Celestone® Soluspan,® and Etrafon.® Our Professional Representatives look forward to your visit.

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

EATON LABORATORIES
Norwich, New York

Booth 22

Your Eaton Representatives wish you a successful 1973 meeting. Complete information on Eaton products and professional services is available at the Eaton exhibit.

EXTRACORPOREAL MEDICAL SPECIALTIES, INC.
King of Prussia, Pennsylvania

Booth 24

Extracorporeal Medical Specialties, Inc., will be exhibiting the complete line of Milroy-Extracorporeal dialysis equipment as well as Extracorporeal's line of disposable dialyzer cartridges, the EX-al, EX-23, EX-01, EX-03 and EX-P. Also featured will be the Swank Transfusion Filter, the Lanz Tracheostomy Tube and Endotracheal Tubes, and the Holter® Infusion Pumps.

Representatives: Bert Rashley and Dick Bauman.

BRISTOL LABORATORIES
Syracuse, New York

Booth 25

THE AETNA CASUALTY & SURETY COMPANY
Hartford, Connecticut

Booth 26

The purpose of this exhibit is to demonstrate many of the causes of malpractice claims and how to avoid them.

Representatives: David C. Kellsey, M. D., D. John Pecorino, LL.B., and F. M. Taylor.

E. R. SQUIBB & SONS
New York, New York

Booth 27

WYETH LABORATORIES
Philadelphia, Pennsylvania

Booth 28

Wyeth will feature . . . Ovral® (each tablet contains 0.5 mg. norgestrel with 0.05 mg. ethinyl estradiol) Wyeth, Tablets; Serax® (oxazepam) Wyeth, Capsules 10, 15, 30 mg. — Tablets 15 mg.; SMA® Improved (Infant Formula) Wyeth — nourishes like Mother's milk; and Tubex® Closed Injection System — 37 different drugs, 71 dosage variations. Full information is available at Booth 28.

COOPER LABORATORIES
Wayne, New Jersey

Booth 29

Cooper Laboratories, Inc., cordially invites members of the Association to visit our booth where Elixophyllin (theophylline elixir), Elixophyllin KI (theophylline potassium iodide elixir), Kay Ciel Elixir (potassium chloride) and Sus-Phrine (epinephrine aqueous suspension) will be on display.

Our representatives will be on hand to provide samples and literature, when requested.

Representative: Donald Lanham.

PHILIPS ROXANE LABORATORIES, INC.
Columbus, Ohio

Booth 30

STATE MEDICAL ASSOCIATION'S GROUP INSURANCE PROGRAM
Charleston, West Virginia

Booth 31

McDonough-Caperton-Shepherd-Goldsmith, administrators of the State Association Group Insurance Program, will have on hand brochures describing each of the programs officially sponsored by the Association. A representative will be available to answer your questions regarding the operation of the plans available. The program has been in successful operation for over 25 years. Don't overlook the opportunity to obtain sound protection at low group rates.

Representatives: A. B. Daniel and J. Banks Shepherd.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin

Booth 32

General Medical WEST VIRGINIA
Huntington, West Virginia

Booth 42

The same people in the same Booth, but with a NEW NAME. We have been looking forward to saying "Hello" to all our old friends and to extending a warm welcome to all the new members and visitors to this meeting. Be sure to come by and see us. We will have something new to show you. Don't miss seeing the new and more brightly illuminated Welch Allyn "Halogen" Lamp Otoscopes and Ophthalmoscopes.

Representative: Roy Childers.

MEDICAL PLASTICS LABORATORY, INC.
Gatesville, Texas

Booth 43

Thousands of progressive physicians use our models to review anatomy and build better patient relationships through confidence and understanding when explaining diagnosis and surgical procedures.

Representative: Edwin L. Reaves.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

Booth 44

Saunders will have on display a complete line of their medical books, including many new titles and new editions published since last year's meeting. Do stop at our booth!

Representative: John Norton.

HOSPITAL AND PHYSICIANS SUPPLY COMPANY
Charleston, West Virginia

Booth 45

Hospital and Physicians Supply Company's exhibit will consist of diagnostic equipment.

Representative: Doug Carte.

ANNUAL REPORTS

Cancer Committee

A meeting of the Cancer Committee was held at The Greenbrier on August 25, 1972, during the 105th Annual Meeting of the West Virginia State Medical Association.

In addition to your Chairman and several members of the Committee, guests at the meeting included Dr. N. H. Dyer, State Director of Health; Mr. George Gay of the Division of Vocational Rehabilitation; and Mr. Tim Bradford of the West Virginia Division of the American Cancer Society.

Mr. Gay reported that the Division of Vocational Rehabilitation had worked with 54 cancer patients, including 20 new patients. Eighteen patients have been rehabilitated and are gainfully employed. There is careful consultation between the referring physician and Vocational Rehabilitation before entering patients into the program.

Doctor Dyer reported on activities of the Division of Cancer Control. As presently funded the Division paid only 78 per cent of the hospital bills and 44.6 per cent of the physicians' billing in 1971-72.

Mr. Tim Bradford reported on the program of the West Virginia Division of the American Cancer Society and discussed in some detail the revised Service Program. He also discussed the Reach to Recovery Program for mastectomy patients and plans for a Uterine Cancer Task Force. The West Virginia Division of the American Cancer Society, along with the Division of Cancer Control, continues to support the West Virginia Tumor Registrar's Association.

The Committee recommended that the West Virginia Division of Cancer Control pay physicians their usual and customary fees, and that these fees should include diagnostic and chemotherapeutic care as well as surgical and radiological treatment.

Respectfully submitted,

Alvin L. Watne, M. D.
Chairman

June 19, 1973

Insurance Committee

TWENTY-FIFTH ANNIVERSARY: This is the 25th Anniversary of the establishment of the West Virginia State Medical Association Group Insurance Program. We have something to be proud of.

West Virginia was one of the first state associations in the nation to adopt group insurance for the benefit and use of its members. Our Program served as a guide for many other state and national groups that followed.

From inception, our Group Program has produced a consistent record of sound performance and efficient administration. We have kept pace with the times. Eight separate Plans offer vital personal protection at a substantial savings in cost.

The keystone to the success of our state Program is the fact that it combines the advantage of sound protection and local service. Notwithstanding many competing plans—both individual and group—responsive plans and coordinated personal supervision has continued to attract a substantial majority of our members.

All administrative services—including the processing of applications, billing and collecting premiums, the processing and payment of claims—is performed by our "Resident Administrator." A service representative travels the State and is always available for consultation, coordination of coverage, and to assist when necessary in the filing of claims.

The advantage of the wide scope of coverage, low group rates and complete claim service here in the State cannot be over estimated. With the variation of coverages available and complete flexibility within each plan, a program can be tailored to meet the individual objectives of our members.

The following is a review of the Plans that compose the West Virginia State Medical Association Program of Group Insurance:

MONTHLY INCOME PROTECTION: This Plan offers up to $1,500 a month. Benefits are paid for as long as disability lasts—up to lifetime for accident and up to age 70 for sickness.

OFFICE OVERHEAD EXPENSE: This Plan offers up to $2,000 a month and pays the regular operating cost of your office—including employees' salaries, rent, utilities and other normal expenses. Premiums for this coverage are tax deductible.

FAMILY MAJOR HOSPITAL INSURANCE: This Plan provides $15,000 of coverage. In addition to the named insured, it also includes the insured's spouse and dependent children. The Plan pays 80 per cent of hospital expenses and licensed nursing service.

LIFE INSURANCE: This Plan offers up to $40,000 in units of $10,000 each. Optionally, coverage is available on spouse and children in lesser amounts.

ACCIDENTAL DEATH AND DISMEMBERMENT: This policy pays up to $100,000 for Accidental Death and Dismemberment. Coverage is provided 24 hours a day—at home or away—on or off the job—worldwide.

HOSPITAL MONEY PLAN: This Plan provides $40 a day for each day of hospitalization for a member and spouse. Dependent children may be insured for $20 a day. This Plan is designed to provide the "over and above" expenses that inevitably attend today's hospital confinement.

COORDINATED INVESTMENT SERVICE: Specifically designed for HR-10, this Plan offers mutual funds, fixed or variable annuities, and split funds.

MALPRACTICE INSURANCE: A Group Malpractice Policy was introduced this year. The Plan, underwritten by the Aetna Casualty and Surety Com-

pany, is well underway. Coverage is provided in a "Package Plan" and includes basic malpractice liability; million dollar excess coverage; and office premises liability. Participation continues to grow. The program responds to the serious upward trend in malpractice claims.

SUMMARY: Our State Medical Association has passed an important milestone. As one of the early leaders in the sponsorship of a Group Insurance Program, we pioneered in an area that has since been adopted by virtually every state in the Union—and many national associations. The continued strong support of our membership and sustained growth of the Program attests to the soundness of administration and the responsiveness of our insurance plans.

Respectfully submitted,

C. A. Hoffman, M. D.
Chairman

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James A. Barnes, M. D.
Robert L. Chamberlain, M. D.
John T. Chambers, M. D.
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J. C. Pickett, M. D.
Robert S. Robbins, M. D.

June 21, 1973

Medical Education and Hospitals

The past year saw the fruition of several important goals in continuing medical education. The State Medical Association's procedure for accreditation of continuing medical education programs was initiated, and an expanded Mid-Winter Clinical Conference, as earlier directed by the Committee, was conducted successfully.

The accreditation plan was developed within the past year, and the State Medical Association was approved as an accrediting agency for the American Medical Association.

The first site survey conducted under the accreditation process was at Beckley Appalachian Regional Hospital on May 23, 1973. Members of the survey team, who were appointed by Dr. Pat A. Tuckwiller of Charleston, Committee Chairman, were Drs. William E. Gilmore of Parkersburg, Chairman; Mary Lou Lewis of Charleston, and Richard G. Starr of Beckley. A Review Committee (sub-committee) of this Committee also was appointed by Doctor Tuckwiller to hear the recommendations of the survey team and, in turn, to make recommendations to the full Committee. The Review Committee was appointed on a permanent basis in order to process future reports and recommendations of survey teams. The members of this subcommittee are Dr. Richard V. Lynch, Jr., of Morgantown, Chairman; Dr. George M. Kellas of Wheeling, and Drs. Gilmore, Lewis and Starr.

The Review Committee recommended accreditation for the CME program at the Beckley hospital in the following category: one-year provisional accreditation for a newly-developing program. This recommendation was approved by the Review Committee, meeting with the survey team on the evening of May 23 in Beckley and, in turn, was approved by the full Committee at its meeting on June 17 in Charleston at the Heart-O-Town Motor Inn.

Accompanying the survey team to Beckley on May 23 were Dr. Rutledge W. Howard of Chicago, Associate Director, Department of Continuing Medical Education, American Medical Association; Dr. Ross L. Egger of Daleville, Indiana, a member of the AMA's Advisory Committee on Continuing Medical Education, and Custer B. Holliday, Executive Assistant, State Medical Association.

Formal ratification of the hospital's accreditation is anticipated by the AMA's Council on Medical Education and the Advisory Committee on Continuing Medical Education at their next regular meetings in October.

The effective date of the one-year accreditation period for the hospital was June 17, the date of the Committee's meeting in Charleston. Physicians participating in the CME program at the hospital may count this instruction as hour-for-hour credit toward the AMA's Physician's Recognition Award in Category 1 (Accredited (AMA) programs), effective retroactively to May 23, the date of the survey.

Since the Beckley accreditation, there have been requests for surveys from the Veterans Administration Hospital at Clarksburg, the West Virginia Academy of Ophthalmology and Otolaryngology, and a request for preliminary information from the Veterans Administration Center at Martinsburg.

In brief, the survey procedure involves a period of approximately four months, including the completion of a pre-survey questionnaire by the institution or organization requesting the survey, the site survey, preparation of a team report by the survey team, and action of the Review Committee and the full Committee.

The other major new development in continuing medical education was the Sixth Mid-Winter Clinical Conference, which was expanded to two days to meet the Committee's goal of fewer, but bigger and more effective, clinical sessions for physicians each year.

The Conference, held on January 20-21, 1973 in Charleston at the Heart-O-Town Motor Inn, drew the largest attendance of any of these mid-winter meetings. The over-all registration was 144, including 135 physicians.

Sponsoring groups grew from five the previous year to 10. New sponsors were the State's Orthopedic Section, Arthritis Foundation, Cancer Division, Diabetes Association, and Heart Association. Continuing as sponsors were the State Medical Association, the West Virginia Thoracic Society and

the West Virginia Tuberculosis and Respiratory Disease Association, along with the West Virginia University Medical Center and the State Internal Medicine Chapter.

The conference this coming winter will be further expanded to include a Friday evening session in addition to the scientific programs on Saturday and Sunday. It will be held January 18-20, 1974, again in Charleston at the Heart-O-Town. It presently is anticipated that pediatrics and urology will be among other possible additional specialties to be represented on the program.

In addition to its approval of the Beckley accreditation on June 17, the Committee also voted to make a request to the Council of the State Medical Association to present a resolution before the House of Delegates of the Association at its 1973 Annual Meeting in August at The Greenbrier. The resolution requested calls for the immediate establishment of a Department of Continuing Medical Education at the West Virginia University School of Medicine with the appointment of a full-time director.

The year saw considerable further activity in the Voluntary Office Self-Audit Service (VOSAS) Project, the experimental continuing education program undertaken with Federal funds by the State Medical Association and the West Virginia Regional Medical Program. RMP continued to maintain basic management control of the activity, in coordination with the Committee on Medical Education and the Medical Association.

Upwards of 40 audits were completed or in the final stages as of August 1, and VOSAS at that time was undergoing detailed RMP and Medical Association staff review in the light of impending implementation of the new Federal Professional Standards Review Organization (PSRO) mechanism established by Congress' 1972 amendments to the Social Security Act.

Specifically, VOSAS was being evaluated to determine (1) what data, feasible evaluation procedures and other information it might contribute to development of PSRO activities; (2) the value of certain data giving a general pattern of how many of what kinds of illnesses physicians participating in the project see and treat; and (3) what future value, and format, VOSAS can offer as a continuing medical education process in relation to PSRO, or in other ways.

The past year also saw the appointment of Dr. Richard V. Lynch, Jr., as Vice Chairman of the Committee. He was named by Doctor Tuckwiller to succeed Dr. Daniel Hamaty, who moved out of state. Dr. Mary Lou Lewis of Charleston was appointed a new member of the Committee by Dr. Worthy W. McKinney, President of the State Association.

Appointed as a Medical Association representative to the West Virginia Joint Council on Teaching Hospitals was Dr. George M. Kellas of Wheeling, filling a vacancy caused by the death of Dr. Forest A. Cornwell of Beckley. Doctor Tuckwiller and Dr. David Z. Morgan of Morgantown continued as the other representatives.

Respectfully submitted,

Pat A. Tuckwiller, M. D.
Chairman

July 1, 1973

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

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WVU Medical Center
–News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

FACULTY members at West Virginia University Medical Center often attain national and even international recognition; but probably no honor means more to these teachers than an endorsement from one of the most critical of all groups—their students.

Most recently accorded special tributes from their students at WVU Medical Center were Dr. Sundaram V. Ramanan, Assistant Professor of Medicine, and Dr. James G. Thomas, Associate Professor of Oral Diagnosis and Roentgenology.

For his exceptional teaching, Doctor Ramanan, a hematologist, was chosen by vote of this year's senior class in the School of Medicine to receive its Outstanding Clinician of 1973 Award. The award, an engraved silver plate, was presented to Doctor Ramanan by Gregory Knowlton of Sistersville, class President.

A native of Ceylon, Doctor Ramanan received his medical education at the University of Madras and the Royal College of Physicians in Edinburgh. He completed specialty training at several hospitals in Great Britain and then taught at the University of Manchester for two years before joining the WVU faculty in 1969.

With Margaret Blosser, Chief Technician, Dr. Ludwig Gutmann administers a test in diagnosing botulism poisoning in the EMG Laboratory of the WVU Hospital in Morgantown.

The School of Dentistry Class of 1973, through its President, David G. Edwards of Beech Bottom, presented an engraved plaque to Doctor Thomas naming him as the Outstanding Teacher of the Year.

A graduate of Temple University School of Dentistry, Doctor Thomas joined the WVU faculty in 1967 after more than 20 years in the practice of general dentistry in Reading, Pennsylvania, his home town.

Begins Career in Home Town

Returning to his home town area July 1, as Director of the emergency room at Princeton Community Hospital, was Dr. Ronald M. Cyphers. A graduate of West Virginia University School of Medicine, Doctor Cyphers recently completed an internship in medicine at WVU Hospital and is a member of Alpha Omega Alpha honor medical society. His parents are the Rev. and Mrs. James H. Cyphers of Athens Star Route, Princeton.

Useful Test For Botulism Poisoning

Electromyography studies that measure muscle function in response to electrical impulses are useful in diagnosing botulism poisoning in patients, believes Dr. Ludwig Gutmann. The Professor and Chairman of Neurology at West Virginia University School of Medicine has used the test to confirm seven cases of the rare and sometimes fatal disease which blocks the neuro-muscular junction, preventing release of essentially needed acetylcholine.

The first case at the WVU Hospital in Morgantown was determined by this method in the summer of 1972. Six others were confirmed in the same way by Doctor Gutmann in May at Wheeling Hospital. "In the diagnosis of botulism the technique is relatively new," he said.

WVU Receives Grant

West Virginia University has received a $43,675 grant from the National Heart and Lung Institute to continue a cooperative study of drugs and coronary heart disease. Dr. David Z. Morgan of WVU Medical Center is in charge of the project.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE HEW Department issued interim regulations to guide the new chronic kidney disease treatment benefit program which it estimated will cost $250 million in the first year and could rise to $1 billion a year in five years. The expansion of Medicare to cover costs of kidney dialysis and transplants for beneficiaries of all ages started July 1.

Under interim rules, the number of facilities providing dialysis and transplants has been frozen at those now operating. The regulations also freeze reimbursement to a level of cost or charge representing an average of the charges during the previous year. Reimbursement for maintenance dialysis is limited to a "ceiling" set by the department ($150 per dialysis) above which a justification would be required. All facilities must agree to the assignment method of reimbursement. Final regulations are due by the first of the year.

Senator Bennett Plans To Retire

Sen. Wallace F. Bennett, ranking Republican on the Senate Finance Committee, won't run for reelection next year. The 74-year-old Republican from Utah has served four terms in the Senate. Replacing Bennett as top Republican on the powerful Finance Committee will be Sen. Carl Curtis (R., Nebr.). Senator Bennett, one of the Senate's most influential conservatives, is author of the controversial Professional Standards Review Organization (PSRO) amendment to the Medicare-Medicaid bill of last year. He cited his age as a factor in his decision. "I can't deny the calendar." A few days earlier, Sen. Norris Cotton (R., N. H.) had announced he will not run again.

'Spirit of Partnership'

President Nixon cited "a spirit of partnership" with Congress as he signed a one-year extension of major Public Health Service programs. The extension had been strongly opposed by the Administration which wanted to eliminate five of the 12 programs and cut others.

The Chief Executive declared that the bill strikes "a reasonable compromise with the Administration," noting that it keeps the programs alive for only one year instead of the customary three. In adopting the bill by overwhelming votes, Congress expressed an intention to review the programs to determine if it agreed with the Administration's policy decisions.

The 12 programs involved and the money authorizations for the fiscal year that started July 1 are:

—Health services research and demonstration ($42.6 million); National health statistics ($14.5 million); Public health training ($23.3 million); Migrant health services ($26.7 million); Comprehensive health planning ($360.5 million); Medical libraries ($8.4 million); Hospital construction ($197.2 million); Allied health training ($44.3 million); Regional medical programs ($159 million); Family planning ($118 million); Community mental health centers ($234 million); Developmental disabilities ($41.7 million).

The Administration had urged Congress to eliminate or phase out the hospital construction or Hill-Burton program, public health training, allied health training, regional medical program (RMP) and community mental health centers.

In a statement released with the signing of the bill and two other measures, President Nixon said, "while the authorization levels are higher than I believe desirable, they will not damage our over-all fiscal position if the Congress now follows my recommendations in the appropriations process.

"So long as the Congress follows a responsible course in the passage of future spending bills, I will cooperate in a spirit of partnership. But as we go forward let there be no mistake about one fundamental point: if bills come to my desk which are irresponsible and would break open the federal budget, forcing more inflation upon the American people, I will veto them."

The RMP program has already been disbanded at HEW headquarters. Apparently, some sort of a makeshift arrangement will have to be set up to keep it operating for one more year anyway.

There was only one vote in Congress—by Rep. Philip Crane (R., Ill.) in either house of Congress against the extension bill, which made unlikely any successful veto.

The chief Administration argument for closing down the five programs was that they were inefficient, had outlived their usefulness, or could be handled more appropriately by the states.

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Muriel Dodds, CRNA

Book Reviews

SHOULD PREACHERS PLAY GOD? – By Claude A. Frazier, M.D. Independence Press, Box 1019, Independence, Missouri 64051. 1973.

This book is the product of an unusual undertaking in asking the question of 16 clergymen, 11 of whom are professors, and seven of whom are of the same denomination.

While the book is interesting, one finds the respondents often guilty of doing just what the question asks—playing God. There are numerous criticisms of the actions of clergy, the writer excepted, of course. Nevertheless, the competency of the writers is evident in their works, and both clergy and laity will find new insights and inspiration in the book.—David C. Bane, Rector, Christ Episcopal Church, Clarksburg, W. Va.

* * * *

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY – By Joseph G. Chusid, M.D. Lange Medical Publications, Los Altos, California. 1973. 15th Edition. 429 Pages.

It is a pleasure to review this volume which has been a favorite of medical students, neurology and neurosurgical residents, and others for many years. The author has updated the issue in several areas but the most notable alteration has been a change in type face with a more conventional two-column setting and the addition of approximately 30 new illustrations, most of which are excellent and complement the high quality of the illustrations we have been used to in this volume. I am not sure that the new type face really adds to the readability but it does save space.

This is a highly acceptable book. The following isolated comments are included not to be unduly critical of the book, but to suggest improvements that will make it even more acceptable.

One could seriously question the inclusion in the chapter entitled "Trauma to the Central Nervous System" the entities subtitled "Herniation of Intervertebral Disc," "Low Back Pain," "The Shoulder-Hand Syndrome" and "The Whiplash Injury." These disorders have nothing to do with the central nervous system in the first place and the relationship between the ruptured intervertebral disc, especially in the cervical region, and trauma is highly questionable in the second place. Most workers now

(Continued on page XIV)

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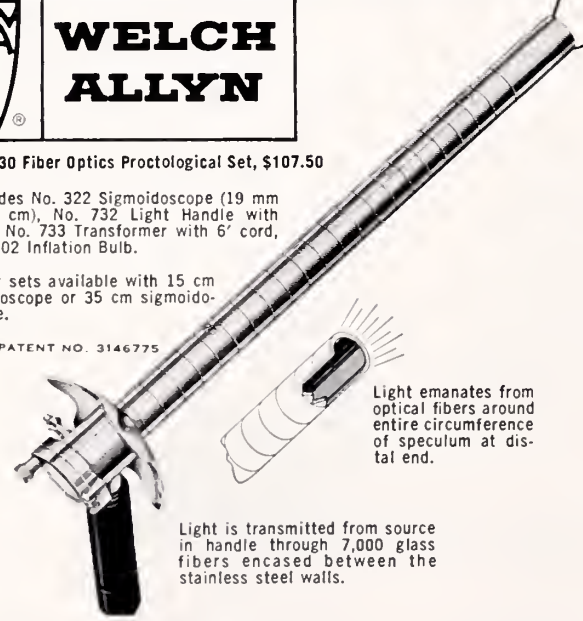

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feel that these are degenerative diseases of the intervertebral disc rather than the result of trauma.

One might like to see included among the causes of ulnar nerve lesions chronic compression at the elbow as is commonly seen as an occupational disorder.

The reader is led to believe that "under normal circumstances each internal carotid artery supplies the ipsilateral cerebral hemisphere, whereas the basilar artery carries blood to structures within the posterior fossa." Actually the basilar artery usually supplies the posterior regions of the cerebral hemispheres via the posterior cerebral arteries.

In the discussion of occult hydrocephalus the occurrence of dementia and ataxia was mentioned but the third component of the triad, incontinence, was left out.

Under the heading of "Clinical Findings in Lesions of the Medulla" we have the subheading "A. Decerebrate Rigidity." Decerebrate rigidity is related to lesions of the rostral pons or midbrain area and not the medulla. One might also question the discussion of the lengthening and shortening reactions and the tonic neck reflexes of Magnus-de-Kleijn under the same heading.

The statement that the aura of epilepsy is a syndrome of the first cranial nerve strikes a discordant note in that this aura is related to the temporal lobe rather than the first cranial nerve.

Tic douloureux is discussed in two areas in the book. In one place it states that the pain lasts "one to two minutes or as long as fifteen minutes" but in the other area it states that this condition causes a pain "usually lasting a fraction of a second to several seconds." The latter is correct. It also states that with trigeminal neuralgia "flushing of the face, watering of the eyes, and running of the nose are also present." This is not true and further compounds the frequent confusion of this condition with the cluster headache which does cause flushing of the face, watering of the eyes and running of the nose. Objection might also be made to the statement that trigeminal neuralgia is sometimes associated with dental or sinus disease. Trigeminal neuralgia is a specific clinical entity and although various etiologies have been ascribed, dental and sinus disease are not in the running.

The discussion of the spinal cord circulation would be improved by the addition of a diagram revealing the longitudinal or vertical relationships of the major feeding vessels of the cord, the sites representing the distal watershed of these vessels, and some mention of the artery of Adamkiewicz.

It is hard to criticize a book which offers so much in such a direct and readable fashion with numerous excellent illustrations. At times, however, it does seem to suffer from trying to offer too much

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for too many. One is left with inadequate discussions of such important entities as temporal arteritis and arsenic intoxications to mention two of several examples.

I will continue to recommend this book to medical students and others preparing for boards or requesting a direct way to get at a source of basic material.—G. Robert Nugent, M. D.

Urging Delay Of Guidelines On Prescription Contents

Spokesmen for drug companies and physicians' groups have urged the Food and Drug Administration to delay guidelines on what cough and allergy prescription products may contain.

"These products have been used safely and successfully by physicians for decades," the American Medical Association told a FDA hearing. Asking no "precipitous action," the AMA said "there is hardly a citizen who has not received some relief from bothersome symptoms via one or more of these products."

John H. Budd, M.D., a member of the AMA Board of Trustees, said the interim guidelines would not serve the public interest. Doctor Budd noted that a FDA panel on over-the-counter drugs is reviewing the OTC situation. "It is apparent that the final monograph that emerges from this review process will have a substantial bearing on the formulation and labeling of prescription as well as OTC drugs . . . and in many respects will determine the related issues," said Doctor Budd.

The proposed interim guidelines were not formulated under the specific requirements of the drug law, he said, "but rather were devised on the basis of subjective judgments made by members of the appropriate drug efficacy study panels."

The AMA official said that if one considers the contribution any one drug may make to a mixture, published evidence as specified in the law does not exist for any of the classes of drugs in cough mixtures: antitussives, expectorants, antihistamines, decongestants, demulcents or flavorings.

"The problem that confronts us is not a simple straightforward one such as determining the effect a drug has on bacterial multiplication, urine output or level of a plasma constituent. Rather we are in the difficult area of subjective human feelings, symptoms with profound psychological as well as physical parameters. The remedies for cough were developed by trial and error over decades and even hundreds of years. The long history behind the expectorant ingredients . . . have put them, in the doses used, to the test of safety and by the impressions of clinicians to the test of effectiveness. How effective they are is difficult to measure since for cough the placebo effect is extremely important. Many coughs respond simply to a drink of water. Other coughs respond to expectorants. Still others respond only to substantial doses of codeine or an equivalent antitussive, and finally some coughs will yield to nothing yet devised."

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42nd AAP Annual Meeting In Chicago, Oct. 20-24

Discussions covering a wide range of topics—from drug abuse to the sudden infant death syndrome to human sexuality to learning disorders — will highlight the 42nd Annual Meeting of the American Academy of Pediatrics, October 20-24 in Chicago.

The meeting, to be held at the Palmer House Hotel, will open with one and two-day seminars Saturday and Sunday. General sessions will run Monday morning, Tuesday afternoon, and all day Wednesday. Open section meetings and round table discussions also are included in the meeting program.

Round table discussions planned for the meeting include: dermatology, child development, day care centers, pulmonary disorders, allergy and screening.

The seminars will concentrate on such topics as immunology, behavioral problems, growth disorders, renal disease, and adolescence.

The open section meetings will include programs by the sections on urology, surgery, diseases of the chest, military pediatrics, community pediatrics, child development, pediatric cardiology, allergy, and anesthesiology.

The meeting is expected to attract more than 4,500 persons including pediatric specialists from throughout the western hemisphere.

The American Academy of Pediatrics is the Pan-American association of physicians certified in the care of infants, children, and adolescents. The Academy's stated goal is "the attainment by all children of the Americas of their full potential for physical, emotional, and social health." The AAP has more than 14,000 members in North and South America.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

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GENERAL SURGEON WANTED—Must have necessary qualities for advancement to Chief of Staff or Medical Director. Salary open. Medium size hospital in Southern West Virginia. Fully accredited with modern furniture and equipment. Contact CAW, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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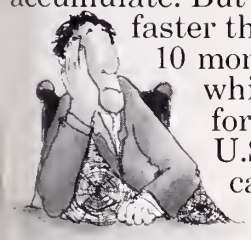

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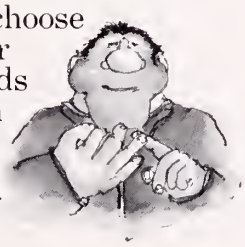

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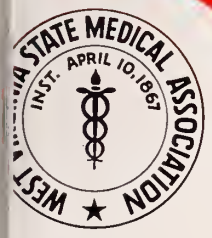

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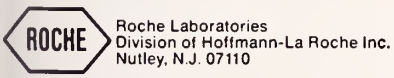

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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SEPTEMBER
1973

Vol. 69 No. 9

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Member 1973

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After a rheumatoid arthritic flare-up.

ortant Note: This drug is not a simple analgesic Do
ıdminister casually Carefully evaluate patients be-
starting treatment and keep them under close su-
ision. Obtain a detailed history, and complete
ical and laboratory examination (complete hemo-
ı, urinalysis, etc.) before prescribing and at fre-
ıt intervals thereafter Carefully select patients,
ding those responsive to routine measures, contra-
ated patients or those who cannot be observed fre-
ıtly. Warn patients not to exceed recommended
ge Short-term relief of severe symptoms with the
lest possible dosage is the goal of therapy Dosage
ıld be taken with meals or a full glass of milk. Sub-
te alka capsules for tablets if dyspeptic symptoms
ır Patients should discontinue the drug and report
ediately any sign of fever, sore throat, oral lesions
ıptoms of blood dyscrasia); dyspepsia, epigastric
, symptoms of anemia, black or tarry stools or other
ence of intestinal ulceration or hemorrhage, skin re-
ons, significant weight gain or edema A one-week
period is adequate. Discontinue in the absence of a
ırable response. Restrict treatment periods to one
k in patients over sixty
cations: Acute gouty arthritis, rheumatoid arthritis,
ımatoid spondylitis
traindications: Children 14 years or less, senile pa-
's; history or symptoms of G I. inflammation or ul-
ition including severe, recurrent or persistent dys-
sia; history or presence of drug allergy; blood
rasias; renal, hepatic or cardiac dysfunction; hy-
ension; thyroid disease, systemic edema;
ıatitis and salivary gland enlargement due to the
j, polymyalgia rheumatica and temporal arteritis;
ents receiving other potent chemotherapeutic
ıts, or long-term anticoagulant therapy
nings Age, weight, dosage, duration of therapy, ex-
ıce of concomitant diseases, and concurrent potent
notherapy affect incidence of toxic reactions Care-
instruct and observe the individual patient, espe-
the aging (forty years and over) who have
eased susceptibility to the toxicity of the drug. Use
est effective dosage Weigh initially unpredictable
efits against potential risk of severe, even fatal, re-
ons The disease condition itself is unaltered by the
ı Use with caution in first trimester of pregnancy

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and in nursing mothers. Drug may appear in cord blood and breast milk Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G I. tract has occurred The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents Carefully observe patients taking these agents Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid) Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage If edema occurs in patients over sixty, discontinue drug.
Precautions The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc Cases of leukemia have been reported in patients with a history of short- and long-term therapy The majority of these patients were over forty Remember that arthritic-type pains can be the presenting symptom of leukemia
Adverse Reactions This is a potent drug, its misuse can lead to serious results Review detailed information before beginning therapy Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G I bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement (B)98-146-070-H(10/71)

For complete details, including dosage, please see full prescribing information

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Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

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sleep for 7 to 8 hou without need to repeat dosage

No sleep n cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pat given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer n time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to re dosage during the night.

eep with onsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a zodiazepine specifically indicated for insomnia. It is not a bar-ate or methaqualone, nor is it related chemically to any other lable hypnotic.

When your evaluation of insomnia indicates the need for a sleep lication, consider Dalmane—a single entity nonnarcotic, non-biturate agent proved effective and relatively safe for relief of mnia.

DALMANE®
(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving) Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances

Dosage: Individualize for maximum beneficial effect *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl

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Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

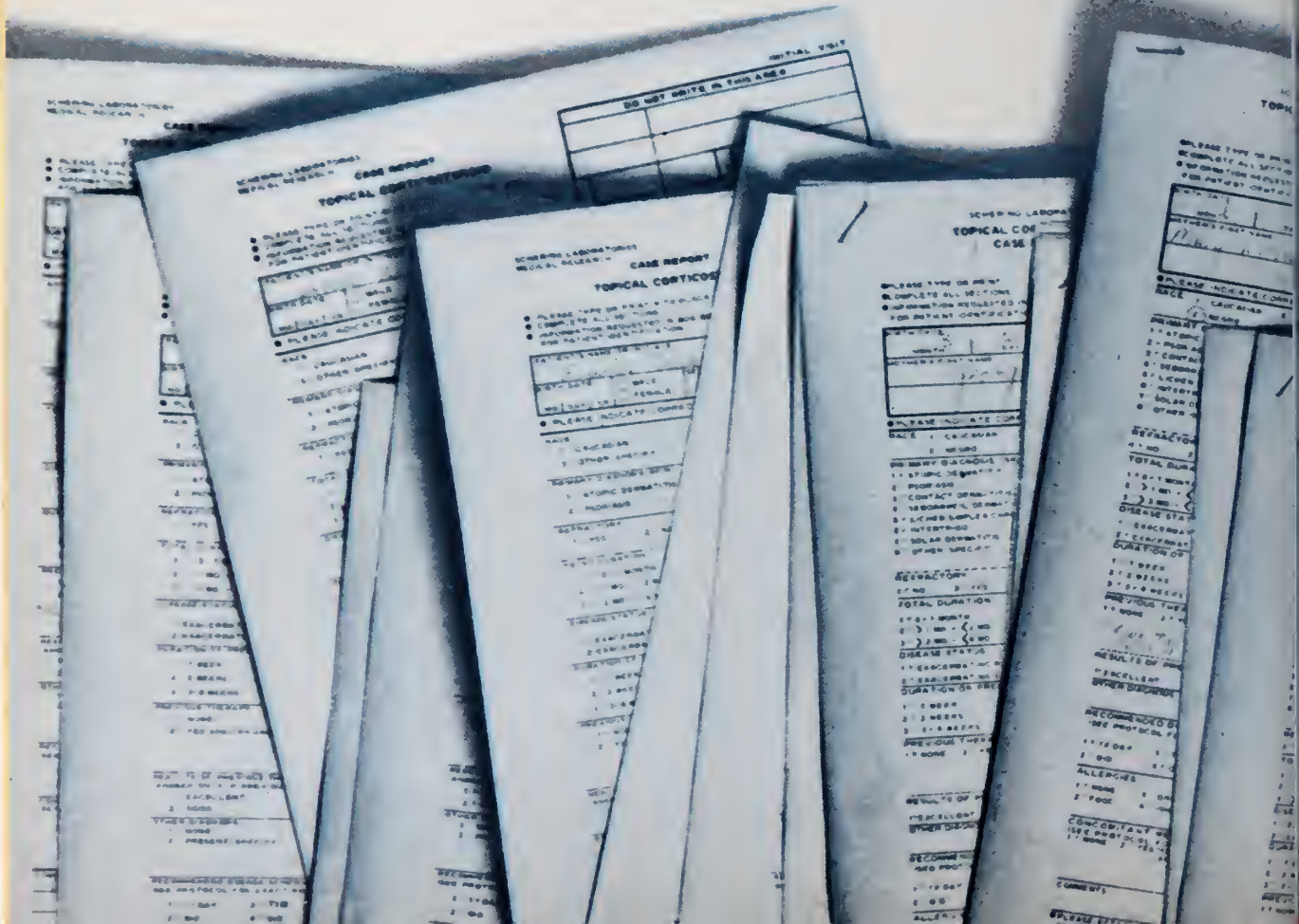
A topical steroid that has clinically succeeded

in study...after study...after study[1-6]

Excellent/good results

85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic ecz *(231 of 251 patients)*[1]



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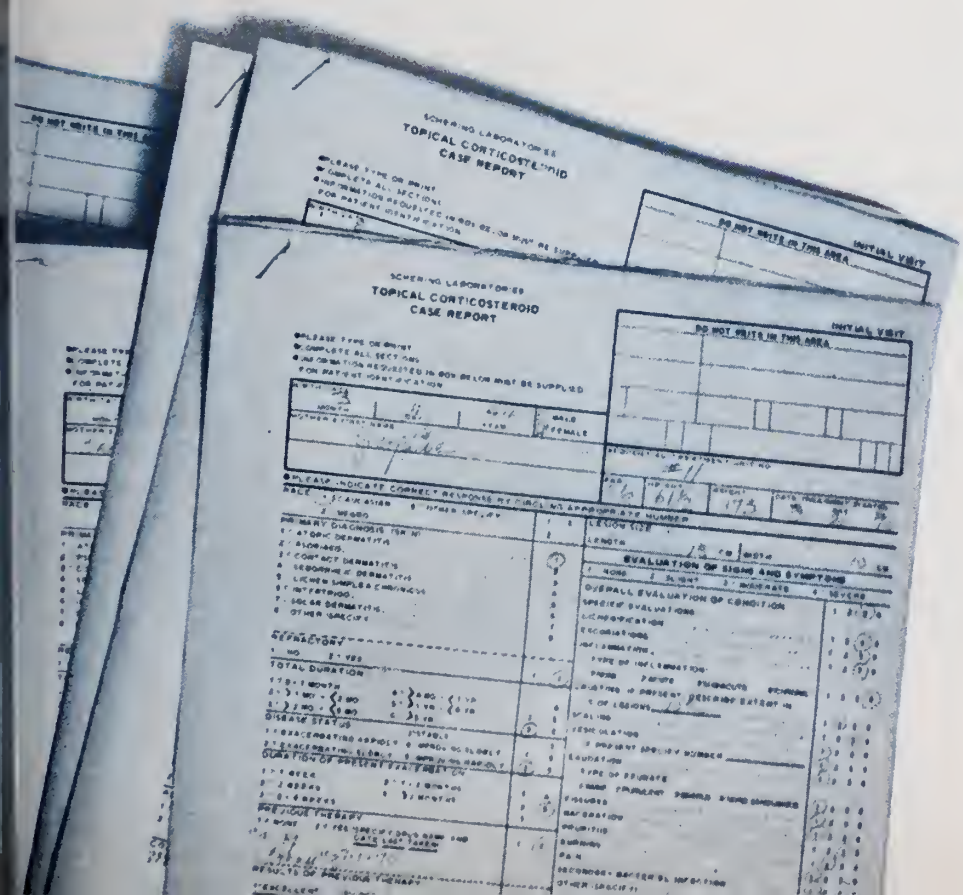
(81 of 84 patients)[1]



CLINICAL CONSIDERATIONS:

Description VALISONE products cont betamethasone valerate (9-fluoro-11$_\beta$,17,21-trihydroxy-16$_\beta$-methylpregna-1,4-diene-3,2 dione 17-valerate). Each gram of VALISON Cream 0.1% contains 1.2 mg. betamethason valerate (equivalent to 1.0 mg. betamethaso in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol monocetyl ether, cetostearyl alcohol, monob sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. gram of VALISONE Ointment 0.1% contai 1.2 mg. betamethasone valerate (equivalent 1.0 mg. betamethasone) in an ointment base liquid and white petrolatum, and hydrogen lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticoster responsive dermatoses.

Contraindications VALISONE Cream Ointment are contraindicated in vaccinia an varicella. Topical steroids are contraindicate those patients with a history of hypersensiti to any of the components of the preparation

Precautions If irritation develops with t use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appro priate antifungal or antibacterial agent shou instituted. If a favorable response does not occur promptly, the corticosteroid should b discontinued until the infection has been ad quately controlled. If extensive areas are tre or if the occlusive technique is used, the pos sibility exists of increased systemic absorpti the corticosteroid and suitable precautions s be taken. Although topical steroids have not been reported to have an adverse effect on p nancy, the safety of their use in pregnant fen has not been absolutely established. Theref they should not be used extensively in pregr patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Oi ment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosi acneform eruptions, and hypopigmentation. following may occur more frequently with occlusive dressings than without such therap maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a th film of VALISONE Cream or Ointment to affected skin areas one to three times a day. Clinical studies of VALISONE have indicat that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Sch literature available from your Scherin Representative or Professional Service Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

ROCHE announces new BACTRIM™

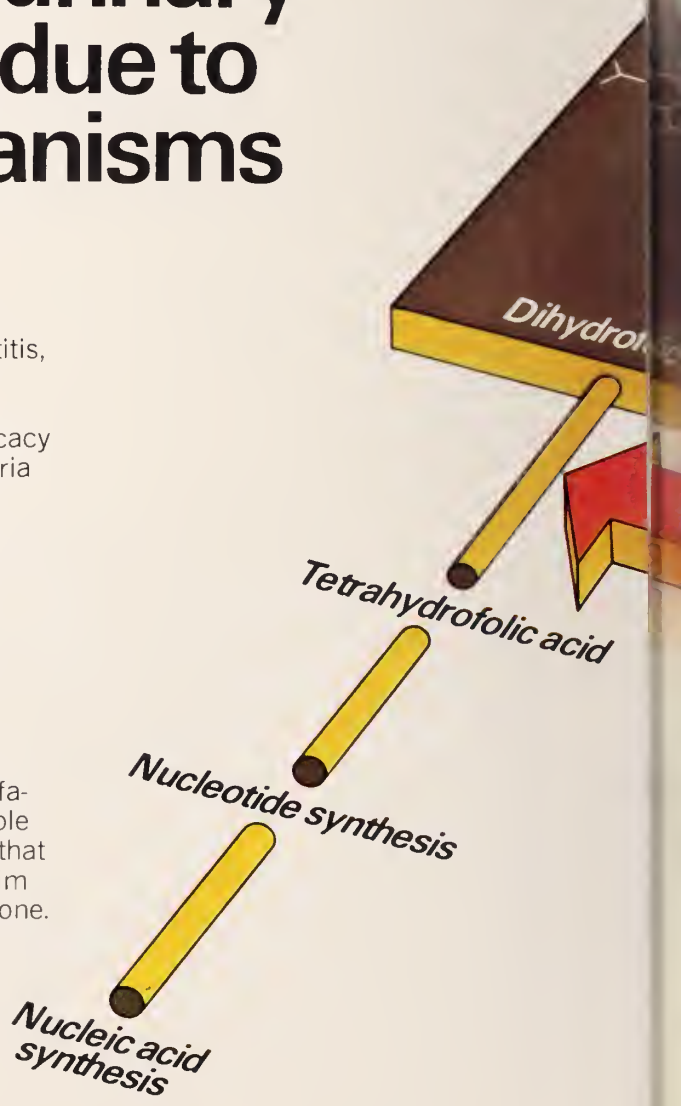
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

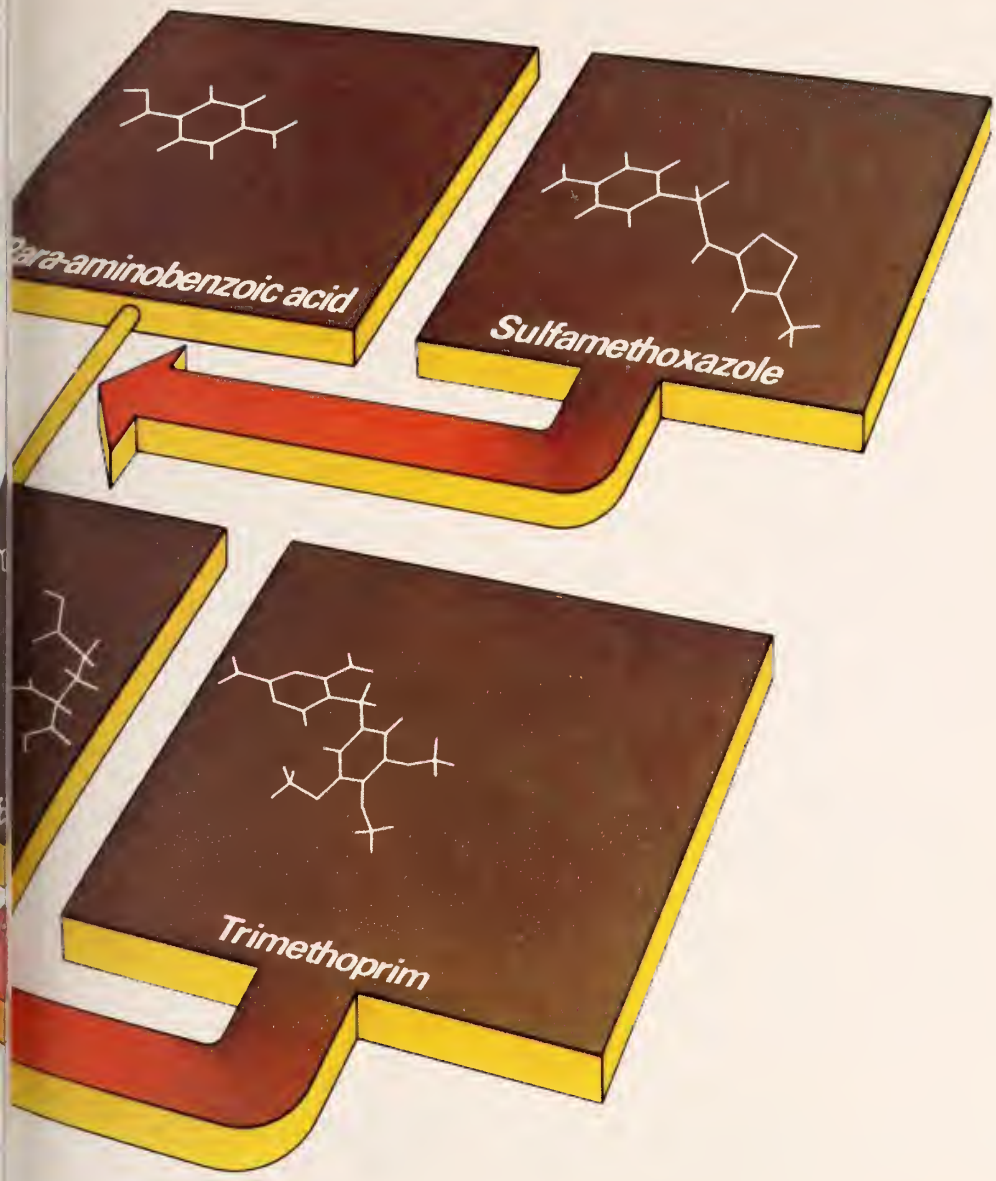
Bactrim is highly effective in the treatment of these infections – primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



ROCHE

Interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

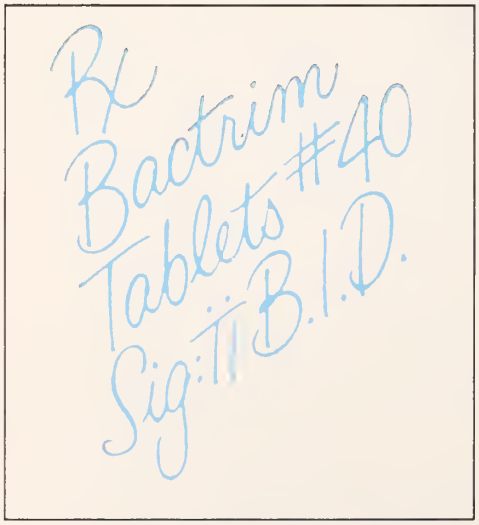
Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

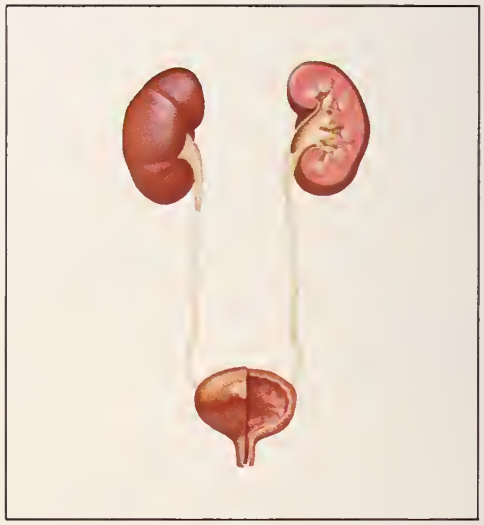
Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
† 4 patients not available for evaluation at day 10.





new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley N J 07110

Before prescribing, please consult complete product information on facing page.

ɔlete Product Information:

ription: Bactrim is a synthetic antibacterial combination prod- available in scored light-green tablets, each containing 80 mg ɜthoprim and 400 mg sulfamethoxazole.

ethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. ɜ white to light-yellow, odorless, bitter compound with a molec- weight of 290.3.

ımethoxazole is N^1-(5-methyl-3-isoxazolyl)sulfanilamide. It is most white in color, odorless, tasteless compound with a mo- ar weight of 253.28.

ns: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis hydrofolic acid by competing with *para*-aminobenzoic acid. ethoprim blocks the production of tetrahydrofolic acid from di- ɔfolic acid by binding to and reversibly inhibiting the required me, dihydrofolate reductase. Thus, Bactrim blocks two con- tive steps in the biosynthesis of nucleic acids and proteins ntial to many bacteria.

tro studies have shown that bacterial resistance develops more ly with Bactrim than with trimethoprim or sulfamethoxazole ɜ.

tro serial dilution tests have shown that the spectrum of anti- erial activity of Bactrim includes the common urinary tract ogens with the exception of *Pseudomonas aeruginosa*. The fol- ıg organisms are usually susceptible: *Escherichia coli, Kleb- ɜ-Enterobacter, Proteus mirabilis* and indole-positive proteus ies.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

teria	Trimeth- oprim alone	Sulfameth- oxazole alone	TMP/SMX (1:20) TMP	SMX
herichia	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
teus spp. ole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
teus abilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
bsiella- erobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

ıan Pharmacology: Bactrim is rapidly absorbed following oral ıinistration. The blood levels of trimethoprim and sulfamethoxa- are similar to those achieved when each component is given e. Peak blood levels for the individual components occur one ıur hours after oral administration. The half-lives of sulfameth- ɔle and trimethoprim, 10 and 16 hours respectively, are rela- y the same regardless of whether these compounds are admin- ed as individual components or as Bactrim. Detectable unts of trimethoprim and sulfamethoxazole are present in the d 24 hours after drug administration. Free sulfamethoxazole trimethoprim blood levels are proportionately dose-dependent. ɜpeated administration, the steady-state ratio of trimethoprim ılfamethoxazole levels in the blood is about 1:20.

amethoxazole exists in the blood as free, conjugated and pro- bound forms; trimethoprim is present as free, protein-bound metabolized forms. The free forms are considered to be the apeutically active forms. Approximately 44 percent of trimeth- m and 70 percent of sulfamethoxazole are protein-bound in the d. The presence of 10 mg percent sulfamethoxazole in plasma ɜases the protein binding of trimethoprim to an insignificant ɜee; trimethoprim does not influence the protein binding of amethoxazole.

ɜtion of Bactrim is chiefly by the kidneys through both glomer- filtration and tubular secretion. Urine concentrations of both amethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together n Bactrim, neither sulfamethoxazole nor trimethoprim affects urinary excretion pattern of the other.

cations: Chronic urinary tract infections (primarily pyelonephri- pyelitis and cystitis) due to susceptible organisms (usually *coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less fre- ntly, indole-positive proteus species).

***ortant note:* Currently, the increasing frequency of resistant organ- s is a limitation of the usefulness of all antibacterial agents, espe- y in the treatment of chronic and recurrent urinary tract infections.**

traindications: Hypersensitivity to trimethoprim or sulfonamides. gnancy and during the nursing period (see Reproduction dies).

nings: Deaths associated with the administration of sulfonamides e been reported from hypersensitivity reactions, agranulocyto- aplastic anemia and other blood dyscrasias. Experience with ıethoprim alone is much more limited, but it has been reported nterfere with hematopoiesis in occasional patients. In elderly ents concurrently receiving certain diuretics, primarily thia- ɜs, an increased incidence of thrombopenia with purpura has n reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Servi

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbi and Mortality Weekly Report*, the Ad ory Committee on Immunization P tices of the United States Public He Service presented recommendations the use of combination live virus vacci The committee stated that:

- "Data indicate that antibody respo to each component of these combina vaccines is comparable with antibody sponse to the individual vaccines gi separately.
- "There is no evidence that d verse reactions to the combi products occur more fe quently or are more sev than known reactions to individual vaccines (see tinent ACIP recommen tions).
- "The obvious convenie of giving already selec antigens in combined f should encourage consid tion of using these prod when appropriate."

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

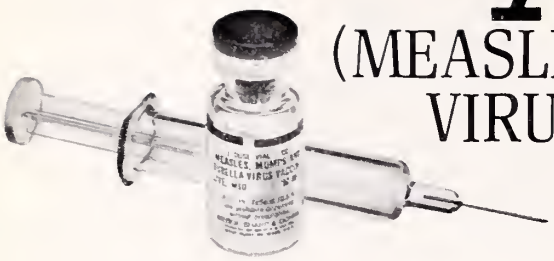
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol SODIUM
(SODIUM BUTABARBITAL)

Contraindications: Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

Synthroid®
(sodium levothyroxine)

the smooth road to thyroid replacement therapy.

Synthroid is T4. It provides your patients with what is needed for complete thyroid replacement therapy.

Free Tab-Minder sample packages available from Flint Professional Services Department.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patien with cardiovascular disease; development c chest pains or other aggravations of cardiova cular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myoca dial infarction. **Side effects:** The effects of SYN THROID (sodium levothyroxine) therapy are slo in being manifested. Side effects, when they d occur, are secondary to increased rates of bod metabolism; sweating, heart palpitations wit or without pain, leg cramps, and weight loss Diarrhea, vomiting, and nervousness have als been observed. Myxedematous patients wit heart disease have died from abrupt increase in dosage of thyroid drugs. Careful observatio of the patient during the beginning of any thy roid therapy will alert the physician to any un toward effects.

It has been shown that *Synthroid* (T_4) converts to T_3 at the cellular level to supply metabolic needs.[1,2]

1 *Synthroid* is T_4.

2 Because T_4 converts to T_3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1,2]

3 T_4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U. S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid®
(sodium levothyroxine)

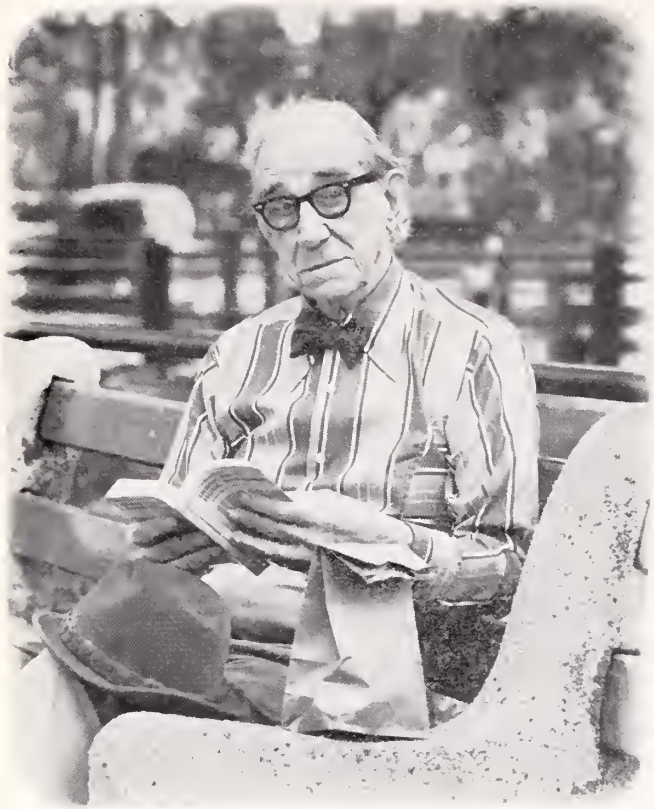
In most cases with side effects, a reduction of osage followed by a more gradual adjustment pward will result in a more accurate indication f the patient's dosage requirements without the ppearance of side effects.

Dosage and Administration: The activity of 0.1 mg. SYNTHROID (sodium levothyroxine) ABLET is equivalent to approximately one grain hyroid, U.S.P. Administer SYNTHROID tablets s a single daily dose. In hypothyroidism without myxedema, the usual initial adult dose is .1 mg. daily, and may be increased by 0.1 mg. very 30 days until proper metabolic balance is ttained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. in adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015



You're never too old to yearn.

When you retire, you'll still want to take vacations.

When you retire, you'll still want to buy new clothes, have an occasional night out, drive a newer car, buy gifts, and be independent.

Will you be able to?

If you have your health there's only one thing that's going to keep you from living the way you want to. Lack of money.

That's where U.S. Savings Bonds come in. You can join the Payroll Savings Plan where you work right now. That way an amount you specify will be set aside from your paycheck and used to buy Bonds. It's an almost painless way to save, and before you know it, you'll have a sizeable nest egg built up for your retirement years.

U.S. Savings Bonds. Because you want to retire from work, not from living.

Take stock in America.

Buy U. S. Savings Bonds

Now E Bonds pay 5½% interest when held to maturity of 5 years, 10 months (4% the first year). Bonds are replaced if lost, stolen, or destroyed. When needed they can be cashed at your bank. Interest is not subject to state or local income taxes, and federal tax may be deferred until redemption.

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You get a package of personal and professional services and benefits you've probably never been fully aware of.

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We can do much more together.
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535 N. Dearborn St./Chicago, Ill. 60610

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indif ent to the economic consequence their decisions." So stated a recer issue of *Medical News Report* (De cember 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasir game, M.D.

Doctor, are you indifferent...?

In discussing an anticipated crease in Blue Shield rates, Dr. Bl ingame's newsletter had this to sa

"In general, it can be said, M have given the impression they ar not particularly concerned with th increase in cost of health care to t patients...

"True, an MD's training is pri marily scientific, but in the real wo of practice, all of his scientific dec sions have a price tag, or an econo impact. The economics of health c beckon the practitioner's attentior Concern for economics of medicin

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inte ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent o demur. Without that opportunity, t unilateral decision of the pharmaci made in the absence of clinical knc edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is nothi in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

Advertisement

d be an obligation of medical ce...

'Medical societies ought to con- continuing campaigns to point e substantial savings that could alized thru deductible insurance rotection for catastrophic ill- At the very least, they should, in atients' interest, question the s of any insurance organization aises health care costs by forc- olicyholders to buy insurance may not need or want and prob- von't ever use.

"Too many doctors are indiffer- the economic consequences of decisions. Too many, for ex- e, habitually hospitalize patients e convenience of the MD. It's ense to deny such habits exist...

"Doctors, thru their medical so- es, have unhesitatingly appealed eir patients for support in the against government interference the private practice of medicine. the public in the past has re- ded. It's time the American Med- Association and state and local ical societies paid off the debt by sive action to hold down the cost edical care."

of Drugs

Insurance rates and hospital ges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

) drugs that he selects to treat the rity of conditions encountered in ractice. Moreover, the physi- 's choice of a specific brand is ed on his knowledge of the pa- t's medical history and current dition, and his experiences with particular manufacturer's duct.

Some substitution proponents e argued that the dispensing of a scription is a simple two-party saction between the pharmacist the patient, and that a substitut- pharmacist may avoid even a nical breach of contract by simply fying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted iout physician approval and who ertook a legal defense that seeks nake the patient responsible for pharmacist's actions.

uced Prescription Prices?

Substitution advocates are gesting to the consumer, and par- ularly the consumer activist, that uced prescription prices could ow legalization of substitution. have seen absolutely no evidence ustify this claim. To the contrary, erience in Alberta, Canada, where stitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

Clean sweep

with a single dose of Antiminth (pyrantel pamoate) ORAL SUSPENSION

Highly effective against
nworm and roundworm

Non-staining to teeth
oral mucosa on ingestion, to
ols, clothing, linen

Simple dosage with a
gle-dose regimen: 1 cc. per
-lb. body weight (1 tsp./50 lb.;
ximum dose, 4 tsp.)

Well-tolerated, based on clinical studies*

Pleasant-tasting, easy-to-take, caramel-flavored oral suspension

Economical, because one prescription can treat the entire family

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

ANTIMINTH®
(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

While Antiminth is highly effective against pinworms and roundworms, the illustration is not meant to imply 100% efficacy.
*Data on file at Roerig.

Please see prescribing information on facing page.

new

DARVOCET-N®

50 mg. propoxyphene napsylate
and 325 mg. acetaminophen

Lilly TABLETS

Additional information available to the profession on request.
Eli Lilly and Company, Indianapolis, Indiana 46206

300104

The West Virginia Medical Journal

Vol. 69, No. 9 September, 1973

Soft Contact Lenses in the Treatment of Corneal Disease

Marion C. Korstanje, Jr., M. D., and James R. Cook, M. D.

The soft contact lens has created considerable excitement in the field of ophthalmology for cosmetic visual purposes. Comfort and wearing tolerance have been considered to be among the major advantages of this new hydrophilic contact lens. The soft lens also has been increasingly utilized in the treatment of several corneal disease processes. Reported in this paper are eight cases of patients with significant corneal disease associated with ocular pain, injection, epiphora and visual loss who showed considerable improvement when treated with the soft contact lens.

The contact lens employed is composed of a loosely-polymerized methacrylate material first employed in contact lens use in Czechoslovakia over twelve years ago.[1] A commercially available soft contact lens currently marketed under the name Soflens® (Polymacon—Bausch & Lomb) is composed of over 38 per cent water when in the fully hydrated state. The high water content of the polymer contributes to its nonrigid, flexible structure, thereby adding greatly to patient wearing comfort. The 12 mm. diameter of the lens permits the entire cornea to be covered by a clear, flexible "bandage." Kaufman[2, 3] and other investigators[4, 7] have shown many diseased corneas to respond favorably to the protection offered by this bandage effect.

In the following reported cases the Soflens was employed only after more conventional means of treatment proved unsuccessful. These patients all had ocular pain as the major clinical complaint. Medications, artificial tears and pressure patching were found to be ineffective in improving patient comfort. The ocular pain always resulted from defects in the epithelial layer or outer covering of the cornea.

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Case Reports

Corneal Ulcer. — Case 1 was a 67-year-old man who presented to the ophthalmologist describing an intermittently painful left eye of several weeks' duration, becoming acutely worse the day prior to examination. He reportedly sustained an untreated acute episode of presumed herpes zoster ophthalmicus in the left eye some 14 months earlier. Visual acuity was corrected to 20/20 in the right eye but greatly reduced in the left eye (finger counting ability limited to a two-foot distance). A large ulceration of the central cornea was observed on biomicroscopic examination, with the ulcer bed filled with a mucopurulent exudate. Cultures of the scraping of this ulcer bed were negative on blood agar and Sabouraud's media. At the first examination he was started on Chloromycetin ophthalmic drops. By the third and fifth days the ulcer showed a less purulent appearance but showed no signs of diminishing in size or of re-epithelializing; the patient continued to complain bitterly of ocular pain. A soft contact lens was fitted to the left eye as a bandage without regard to visual correction. The patient reported the pain to subside immediately. Fourteen days later he was free of pain and the ulcer was nearly healed.

Moorens Corneal Ulcer. — Case 2 was a 65-year-old woman who reportedly struck her left eye on the edge of a box of facial tissue a week prior to examination.

She had experienced considerable pain and presented with a corrected vision of 20/50 in the right eye and a 20/70 vision in the left eye. Slit-lamp examination revealed a 3 mm. superficial

corneal ulcer. The edges and base of the ulcer were clear and the eye was moderately injected. Neosporin ointment, Chloromycetin solution and a pressure dressing were prescribed. After two weeks of treatment the patient still complained of pain and the ulcer showed no improvement. A possible etiology of herpes simplex keratitis was entertained and topical Indoxouridine (IDU) ointment was prescribed along with judicious amounts of sulfas and steroids. After an additional week there was no improvement in comfort, the ulcer was more widespread, and limbal pannus had developed prompting the clinical diagnosis of Mooren's ulcer. Five weeks after the original injury the patient was hospitalized and a conjunctival flap was pulled over the ulcer; two and one-half weeks later the flap retracted and the ulcer showed no signs of improvement. A soft contact lens was placed on the affected eye and the patient experienced prompt remission of pain. Four days later the ulcer was observed to have re-epithelialized and 10 days after soft lens insertion the lens was removed and the patient remained free of problems.

Ruptured Corneal Epithelial Blebs. — A 76-year-old man (Case 3) presented to the office with constant severe pain in the right eye for over four weeks. The eye showed an old bullous keratopathy with ruptured corneal epithelial blebs secondary to long-standing corneal disease in this aphakic patient. A soft contact lens was placed on the eye, with immediate cessation of pain. The patient was followed very closely and continued to wear the lens day and night for seven months. During that time he was asymptomatic; the lens, however, was lost and within two days the severe pain returned. The patient was given a second lens, the pain again subsided and he continously wears the lens day and night with ocular comfort.

Traumatic Ulcer. — Case 4 is a 57-year-old woman who presented with a painful left eye following injury with a baby's fingernail a few days prior to examination. The right eye was entirely normal with 20/20 uncorrected vision. The left eye was greatly injected, with inferocentral corneal defect.

She was treated variously over the next 23 days with firm pressure dressings, topical sulfa and steroids; Chloromycetin, Gentamycin and a Neosporin steroid medication. A conjunctival flap was then pulled over the ulcer. Eleven days after surgery the flap was retracting and the exposed ulcer showed no signs of healing. Cultures prior to surgery were negative for bacteria and fungi. The ulcer showed grey edges and fungus cultures were repeated after which a soft contact lens was fitted. There was nearly immediate cessation of pain and the ulcer showed a steady progression of healing. The lens was removed four weeks later and the patient remained comfortable.

Corneal Laceration, Localized Keratopathy, Aphakia.—Case 5 is that of a 55-year-old woman who was struck in the right eye with an unidentified missile thrown from a rotary type lawnmower. The projectile struck the globe resulting in a penetrating corneal laceration 5 mm. long, iris prolapse, loss of aqueous from the anterior chamber, as well as injury to the crystalline lens. Repair of the corneal laceration was carried out with No. 10-0 monofilament nylon suture, the prolapsed iris was excised, and the anterior chamber was re-formed while the patient was under general anesthesia. Postoperative recovery was routine; as would be expected in such an injury; however, a secondary cataract developed requiring removal some three and one-half months after the original injury. In addition, a localized bullous keratopathy developed in the site of the corneal laceration and the irregular corneal laceration in the optical axis prevented visual correction better than 20/200 with lenses. A +13.00N soft contact lens was prescribed for the patient, correcting her vision to 20/40, providing comfort and resolution of the epithelial bullous keratopathy, and correcting her monocular aphakia so that she once again has binocular vision. She currently wears the soft contact lens her entire waking hours in the right eye and wears glasses to correct her residual astigmatism in the right eye and her presbyopia. We felt the soft lens to be most beneficial in healing the traumatized right cornea, providing increased patient comfort, correcting an irregular anterior corneal surface, and restoring the eye to useful vision.

Bell's Palsy. — Case 6 involved a 62-year-old woman who developed Bell's palsy affecting the right seventh cranial nerve. She promptly developed paralysis of the orbicularis oculi with inability to close the right eye. This led to an exposure keratitis manifested by pain, injection, epiphora and photophobia of the right eye. On biomicroscopic examination large epithelial corneal defects and punctate corneal staining with fluorescein were observed. Topical artificial tears, ophthalmic ointments, patching and even taping the right eyelid closed provided only temporary and incomplete relief of the patient's problems.

She was subsequently taken to the operating room and under local anesthesia a temporary tarsorrhaphy was done. During the next three weeks the patient experienced some relief but one of the

sutures caused a localized infection in the eyelid resulting in release of the tarsorrhaphy. The patient declined a more permanent form of tarsorrhaphy, the eye became worse with development of a corneal ulcer, increased pain and injection. A soft contact lens was fitted as a bandage lens to the right eye without regard to refractive power. She removed the lens for sterilization once in the early morning and once in the evening and instilled medication at these times. Except during lens sterilization, she wore the lens continuously in the right eye for over five months, with comfort and healing of the sterile corneal ulcer.

She continues to wear the lens while increasing return of the facial nerve motor function is observed. Re-epithelization of the cornea was observed beneath the soft contact lens.

Idiopathic Keratitis. — Case 7 represents a 10-year-old boy with a two-year history of epiphora, photophobia, pain, and moderate visual loss in both eyes. He had previously been treated by a variety of means including topical methylcellulose antibiotics, and steroids as well as patching and ophthalmic ointments. One year prior to the first examination by this physician the child had a corneal ulcer of the right eye resulting in a central corneal scar.

On the initial examination visual acuity was 20/100 in the right eye and 20/80 in the left eye. Corneal sensitivity was reduced in both eyes. Schirmer's tests showed a reflex tearing the eyes were 2 + injected, and the child was frequently blinking and rubbing his eyes.

After unsuccessful trials of artificial tears, steroids and antibiotic ointments and patching, the child was admitted to the hospital for a medical evaluation which proved unremarkable. While hospitalized for five days the conjunctivae were cultured and no pathogens were isolated. While an inpatient, both eyes were patched and the patient's hands restrained so as to prohibit him from further irritation of the eyes by rubbing and scratching. Cycloplegic medications were found to improve comfort. There was felt to be a vicious circle established where ocular pain led to rubbing and scratching the eyes which caused further corneal epithelial irritation, more pain, and the desire to rub the eyes further. After all other avenues of treatment were exhausted, the child was fitted with soft lenses, whereupon comfort was achieved. After six weeks of treatment with the soft lenses, vision without the soft lenses improved to 20/30 in the right eye and 20/25 in the left eye. The corneal epithelium healed, the epiphora abated, and the child became asymptomatic. He currently uses no medication and has not worn the soft lens for over six months.

Keratitis Sicca. — Case 8 is that of a 72-year-old woman with reduced tear secretion and punctate corneal dystrophy in both eyes. She described constant ocular irritation, dry eyes and ocular injection. Vision was limited in each eye due to senile cataracts. Conventional treatment of this keratitis sicca with topical methylcellulose, ointments and patching was only mildly and temporarily successful. Conjunctival cultures failed to demonstrate any pathogens. The lower half of each cornea showed areas of confluent and punctate corneal staining with fluorescein dye. There was a filamentous mucous discharge from both eyes.

The patient was fitted with soft contact lenses. In that she could not achieve insertion and removal of these lenses by herself, she was advised to wear them continuously 24 hours per day with frequent office examinations for sterilization and evaluation. On one occasion she developed a marked iritis in the right eye causing temporary discontinuance of the soft lenses and treatment with topical steroids and cycloplegics. Treatment with soft lenses was resumed and patient comfort was achieved. After six weeks, the epithelial staining and discharge disappeared, and the eyes became quiet. If this condition is maintained, cataract surgery in the future to improve vision is anticipated.

Discussion

The patients in all eight of these cases showed epithelial ulceration of varied degree as a major physical finding. As a result, ocular pain was a major concomitant symptom. It is noteworthy that in most of these cases treatment was directed toward placing some type of protective coat over the exposed cornea ranging from simple emollient eye drops and ointments to conjunctival flaps and tarsorrhaphies prior to fitting the Soflens®: In Cases 3 and 4 (bullous keratopathy and painful corneal scar due to blebs) treatment with the lenses was more direct inasmuch as Case 3 showed a long-standing unrelieved pain complaint and Case 4 benefited from the additional features of optical correction of vision. Almost immediate and continued cessation of pain upon assuming soft lens wear was a typical and gratifying response. In terms of epithelial healing and pain relief, only the lens treatment was successful. Cases 1, 2, 4 and 7, representing trophic ulcer, indolent traumatic ulcer and idiopathic keratitis, respectively, were able to discontinue lens wear after periods ranging from

10 days to 6 weeks. Cases 3, 5, 6 and 8 representing chronic bullous keratopathy, corneal scarring with aphakia, exposure keratitis, and keratitis sicca, respectively, have been obliged to continue use of the lens. In addition to pain relief, it is presumed the lens acts as a protective cover under which the fragile epithelium could restore itself.

The lens has been compared to a splint or bandage in this respect; complete healing in this manner apparently took place in the first group of cases (1, 2, 4, and 7). It is our feeling that use of the soft contact lens offers a modality of treatment which will become a permanent part of the ophthalmic armamentarium.

Summary

Eight cases of corneal disability treated with the Bausch and Lomb Soflens® are reported. Success of treatment in terms of pain relief was achieved in all cases and permanent healing was thought to be accomplished through lens wear in four of eight cases.

A list of references may be obtained by writing The Journal.

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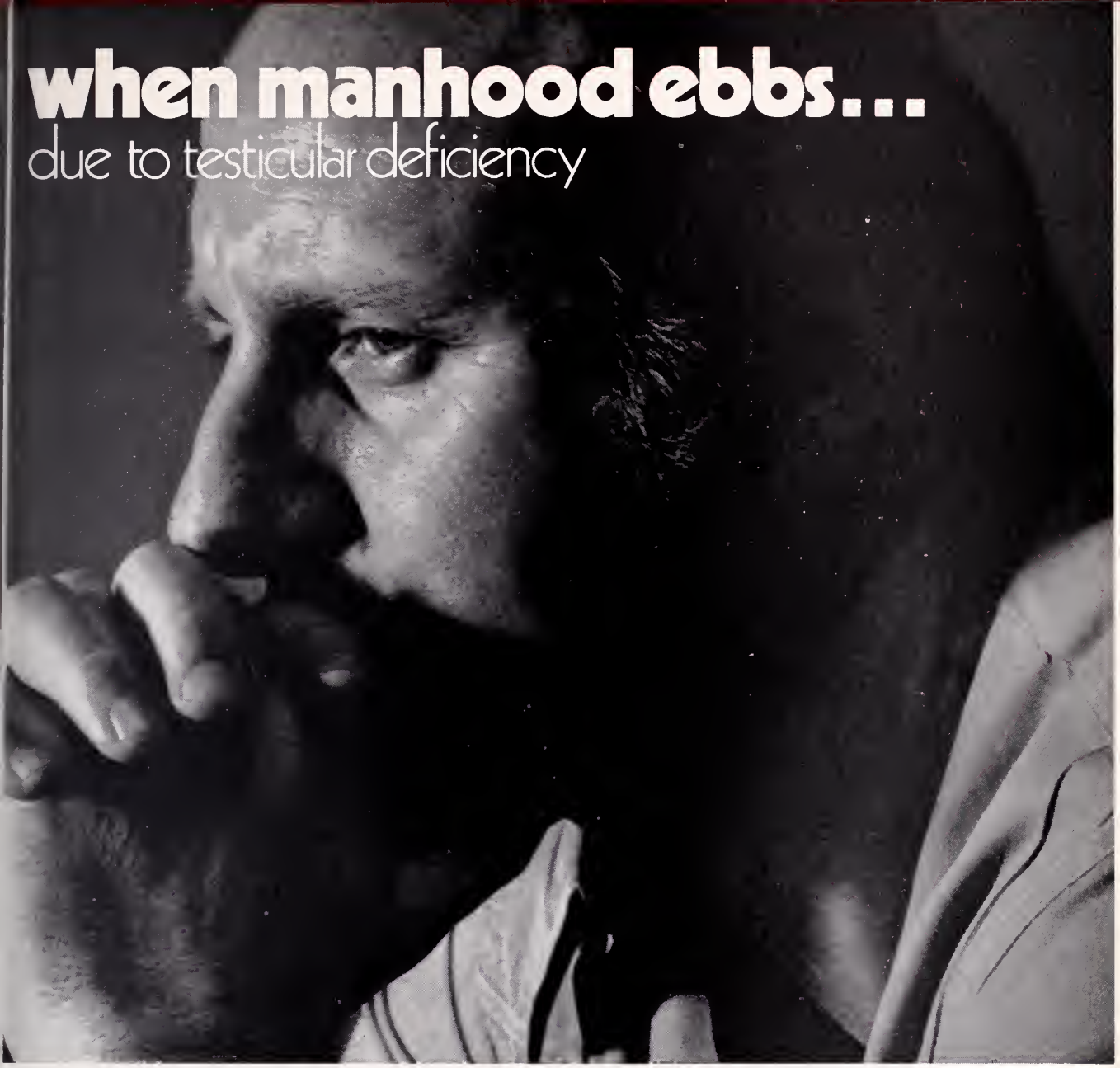

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The Treatment of Seizure Disorders

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A sound therapeutic approach to the problem of seizures requires the initial discussion of some general concepts.

A seizure is the clinical expression of abnormal neuronal discharge and must be considered as a symptom of an underlying dysfunction of the central nervous system. The clinical diagnosis of a seizure is simple if a history of a generalized tonic and later clonic convulsion with loss of consciousness is obtained. The manifestations of a seizure, however, may be subtle and only careful questioning of the patient and witnesses will lead to proper recognition. After the initial diagnosis is made, one must decide whether they are of focal or generalized onset since this may provide a clue for the identification of its cause. Current classification of seizures is based on this distinction.

Partial (Focal) Seizures With or Without Secondary Generalization

These seizures originate in circumscribed areas of the cerebral cortex and the clinical expression varies with the particular function of those areas. The symptoms of these focal seizures may be described as "simple" or "complex."

"Simple" or "elemental" symptoms may be clonic movements in fingers, toes, hand, face, and the like, and they usually originate in the contralateral frontal lobe. Other motor seizures are characterized by more coordinated posturing movements of a limb, i.e., postural, or a turning of eyes or eyes and head (adversive seizure). Other simple, sensory spells are expressed as altered cutaneous sensation, visual, auditory, gustatory or olfactory phenomena. The latter is the so-called "uncinate fit" which originates in the medial temporal cortex. Focal seizures also may be manifested by a variety of elemental symptoms referable to the vegetative system. Focal symptoms may cease or progress such as clonic movements in a distal segment of a limb may spread in an orderly "Jacksonian march" over adjacent areas of the body in seconds or minutes and even lead into a more widespread although still focal seizure.

Other partial (focal) seizures cause a transient derangement of the higher levels of cerebral activity and are manifested by "complex" symptoms. Changes in mood, behavior, thought process, consciousness and bizarre motor activities are some of the more common symptoms. They originate in the frontotemporal areas of the cortex including limbic structures. The most common type in this group is the psychomotor seizure and the usual symptoms are altered emotional behaviour, limited conscious responsiveness to the environment during which time the patient may perform simple or rather complex coordinated, often stereotyped or automatic motor activities. All the partial (focal) seizures, either of simple or complex symptomatology may (and often do) spread into major, tonic-clonic seizures in a matter of seconds or minutes.

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Generalized Seizures From the Onset

In this other major group, the seizures are characterized by a generalized onset and no premonitory symptoms or signs are remembered by the patient or recognized by witnesses. The classic example is the tonic-clonic (grand mal) seizure in which consciousness is lost at the onset together with a generalized tonic muscular stiffening. At this time a guttural cry may be produced by a forced expiration of air through the closed vocal cords and the bladder also may empty at this time (or during the postictal period). This stage is followed by gradual development of clonic, jerking movements which subsequently slow down and end abruptly. Autonomic system signs usually are prominent, and increased salivation with frothing at the mouth as well as changes in pupillary size, respiration, cardiac rhythm and sweating occur. The patient usually is stuporous or confused for a brief period of time after the convulsion.

Petit mal (typical absence attacks) is another type of generalized seizures from the onset. These occur without warning and impairment or lapse of consciousness is the primary symptom. They usually last no longer than 30 seconds and no

visible abnormal movements except for some eye-blinking are present and there are no postictal symptoms. Other types of seizures in the category of generalized from the onset are (1) myoclonic seizures, characterized by brief, abrupt, quick jerking of one or more parts of the body which may throw the patient to the ground; (2) atonic seizures or epileptic drop attacks and (3) akinetic seizures characterized by arrest of movement. The latter two types of seizure and petit mal occur almost exclusively in childhood and adolescence.

In general terms, it may be said that the disorders which cause generalized seizures from the onset are secondary to hypoxic, metabolic, endocrine, toxic or withdrawal states. These are potentially remediable causes and their elimination may result in a complete cessation of seizures. These disorders, however, are found in a small percentage of the patients.

Seizures are much more frequently due to focal damage in the brain secondary to infarctions, brain tumors, abcesses, vascular malformations, degenerative processes and post-traumatic or post-infectious scars. These seizures usually are of focal onset and often with secondary generalization. Unfortunately, in most of these instances, removal of the causal factor cannot be achieved or it results in only partial control of the seizures. Thus, the therapeutic goals for these patients, by far the majority of all patients with seizures, is to prevent the recurrence of spells.

General Principles of Therapy

The treatment of seizures must be started as soon as the diagnosis is made, since delay is unnecessary and may be dangerous. The pertinent medical workup and the likelihood of discovering the underlying cause is not altered significantly. The specific treatment for the causative factor may be started simultaneously. If, however, a definite cause has been found and eliminated, i.e., sleep deprivation, alcohol withdrawal ("rum fit"), the treatment for the seizures may be quickly terminated in a matter of days. For the sake of simplicity and better understanding of drug response, treatment is started with one drug and others are added or discontinued one at a time. The drugs are given whenever possible, in solid form for better quantitation and in divided doses through the day. The dosage of medication varies from patient to patient and thus, individual programs are necessary. The only limiting factors in the use of the drugs is the presence of untoward side-effects or adequate control of the seizure. Often, however, a compromise between control and undesired effects must be maintained. The possibility of drug interactions among anticonvulsants and other drugs must be kept in mind at all times. The medication must be taken regularly and the patient should be advised of the need for a continuous and prolonged period of treatment. The most common reason for failure of seizure control is the irregular and sporadic intake of the anticonvulsant drug. Monitoring of anticonvulsant drug levels in blood provides assistance in this area. The medication may be carefully discontinued at least two to three years after the last seizure. Patients must understand, however, that seizures may recur, particularly in those with neurological deficits or electroencephalographic abnormalities, or both, and many will prefer to continue the medication. The drugs must be discontinued gradually.

Specific Principles of Therapy—The choice of drugs usually is based on the type of seizures suffered by the patient.

Partial (Focal) Seizures With or Without Secondary Generalization—Therapy may be started with sodium diphenylhydantoin (Dilantin) 100 mg. three times daily. If seizures have not been controlled at the end of seven to ten days, at which time constant serum concentrations usually are achieved, the drug may be raised by 100 mg. increments until the seizures abate or symptoms of toxicity appear. Tolerance varies among patients but most adults can take 400 mg. per day without difficulty. The dose for children under the age of 12 years is approximately five mg. per Kg. of body weight per day. At this point, if the seizures continue it is safer to add phenobarbital rather than increase the diphenylhydantoin. Phenobarbital may be given in amounts up to 100-200 mg. daily in divided doses. Two to four mg. per Kg. of body weight per day is recommended for children. Other barbiturates have less potent anticonvulsant effect and therefore offer little in the therapy of seizures. Mephobarbital (Mebaral) is sometimes used when phenobarbital has produced somnolence or hyperactivity. The equivalent dose is twice as large as that of phenobarbital. Primidone (Mysoline) has excellent therapeutic effects and may be used in combination with the diphenylhydantoin and phenobarbital in refractory patients or as a substitute of the latter drug. Primidone is started at small doses, i.e., 250 mg. daily or lower at bedtime and increased at weekly intervals to a level of 1 Gm. daily if necessary. This gradual program for Primidone is advised to avoid the common initial side-effect of drowsiness. The suggested dose for Primidone for children is approximately 25 mg. per Kg. of body weight per day.

Partial (Focal) Seizures with "Complex" Symptomatology—These seizures usually are more resistant to therapy and usually a combination of drugs is needed. Treatment may be started with diphenylhydantoin followed with Primidone and phenobarbital in the dosages suggested previously.

Generalized Seizures from the Onset—These seizures and the petit mal seizures in particular are quite rare and usually respond poorly to the drugs mentioned thus far. In these patients the drug of choice is ethosuximide (Zarontin). It is started in doses of 250 mg. two or three times per day which may be increased at weekly intervals up to 1.5 Gm. (750 mg.-1 Gm. for children) per day if necessary. Trimethadione (Tridione) actually may be more effective but serious toxic side-effects are more frequent and should not be used as a first choice. The starting dose of trimethadione is 300 mg. two or three times per day and increased to four to six times per day (up to 900 mg. per day for children). An alternate approach is to start these patients on phenobarbital which is effective in some cases and of low toxicity. This drug is useful also in protecting patients from grand mal seizures, which frequently are precipitated or increased in frequency by ethosuximide or trimethadione. Acetozolamide (Diamox) 500 to 750 mg. per day (250 to 500 mg. per day for children) also has been found to be of help when given in combination with the other drugs. Methosuximide (Celontin) may be used for petit mal seizures although it is less effective than the drugs mentioned in previous paragraphs.

Untoward Effects

Phenobarbital: Drowsiness is the most common side-effect. It may be encountered at relatively small doses at the beginning of the therapy and subsides with time. Later on, it is due to overdosage and the drug must be decreased. If the drug must be kept at the same dosage, however, small amounts of dextroamphetamine sulfate (Dexedrine), i.e., 5 to 10 mg. per day may be used. Phenobarbital may cause excitation and hyperactivity in some patients, particularly children. Skin rashes occur rarely.

Diphenylhydantoin sodium (Dilantin): The toxic side-effects are rare and mild at average dosage. The most common ones are ataxia, dysarthria, nystagmus, diplopia, dizziness and occasionally drowsiness. The side-effects are due to overdosage and are reduced or abolished by decreasing the dosage. Gingival hypertrophy is another common side-effect and good dental hygiene must be followed as a preventive measure. Mild gastrointestinal symptoms usually are relieved by taking the drug with meals. Acute skin rashes also are encountered occasionally, usually in the second or third week of therapy. The rash usually has a morbilliform appearance and may involve the buccal mucosa. These rashes, as well as more severe exfoliative dermatitis, represent an allergic phenomenon and the drug must be withdrawn. Hypertrichosis occurs in some young patients after a few months of therapy but is rarely marked. Lymphadenopathies resembling lymphoma as well as involvement of the hematopoietic, renal and hepatic systems have been reported rarely.

Primidone (Mysoline): Somnolence is the most common side-effect. For this reason, therapy must be instituted with small amounts and increased slowly in the following few weeks. Ataxia, dizziness, diplopia, dysarthria and nystagmus also may be encountered.

Ethosuximide (Zarontin): Side-effects such as headache, drowsiness, epigastric discomfort and occasional skin rashes have been noted. Depression of hematopsoieses has been noted occasionally.

Trimethadione (Tridione): Toxic side-effects are more common than those of ethosuximide (Zarontin). Photophobia is the most common side-effect and may be helped by wearing tinted glasses. Cutaneous (rash), hematopoietic and renal complications have been described with fatal outcome in some cases.

Methobarbital (Mebaral): The side-effects are similar to those produced by phenobarbital but occur rarely.

Methosuximide (Celontin): The side-effects are generally similar to those caused by ethosuximide (Zarontin).

Acetozolamide (Diamox): The side-effects are minor and consist of paresthesia, anorexia and occasionally drowsiness and confusion.

Periodic blood counts are suggested for patients receiving diphenylhydantoin sodium (Dilantin), Primidone (Mysoline) and methsuximide (Celontin). Urine examinations also are indicated in patients who are on trimethadione (Tridione). These examinations are obtained at one to three month intervals during the first year of therapy and subsequently at six to twelve months intervals.

Surgical Therapy

The indications for surgical treatment are obvious when the seizures are due to a potentially lethal lesion such as a brain tumor or abscess. This is the indicated therapy regardless of whe-

:her the seizures may or may not be controlled ɔy medication.

Surgical treatment of patients suffering from seizures due to non-progressive lesions, however, require great care in selecting the cases. This type of treatment should be considered only when (1) anticonvulsant drugs have failed and significant disabilities occur from frequent seizures, (2) there is a single, consistent, focal origin for the seizures as demonstrated by clinical and electroencephalographic examinations and (3) this focus is in an area of the brain that can be safely removed without causing or adding further disability to the patient. Usually, drug therapy must be continued after surgery.

Treatment of Status Epilepticus

Status epilepticus may be defined as recurring seizures without recovery of consciousness between attacks and is generally applied to grand mal seizures. Status epilepticus is a life-threatening situation and should be attended as a medical emergency. First, maintenance of an open airway and adequate pulmonary ventilation must be obtained. An intravenous infusion is started since the anticonvulsant drugs must be given by this route. The initial therapy consists of sodium phenobarbital five mg. per Kg. of body weight given slowly intravenously and repeated at 15- to 30- minute intervals. If the seizures continue by 30-45 minutes after the second dose, diazepan (Valium) may be tried. This drug is given in doses of five to 10 mg., intravenously over a period of a few minutes. For children, the dose is 0.25 mg. per Kg. of body weight. This is often effective, but repeated doses of diazepam (Valium) or Phenobarbital, or both, may be necessary. If sodium diphenylhydantoin (Dilantin) is used it is advisable to give this drug only in combination with the above mentioned drugs. A single dose of five mg. per Kg. of body weight of sodium diphenylhydantoin (Dilantin) is given slowly intravenously. This drug (if given alone) is less useful in stopping the seizures but when administered in addition to the phenobarbital, it may shorten the duration of the status and has the advantage of being less depressing. Obviously, the precipitating cause of the status epilepticus must be investigated and appropriate measures taken to correct it.

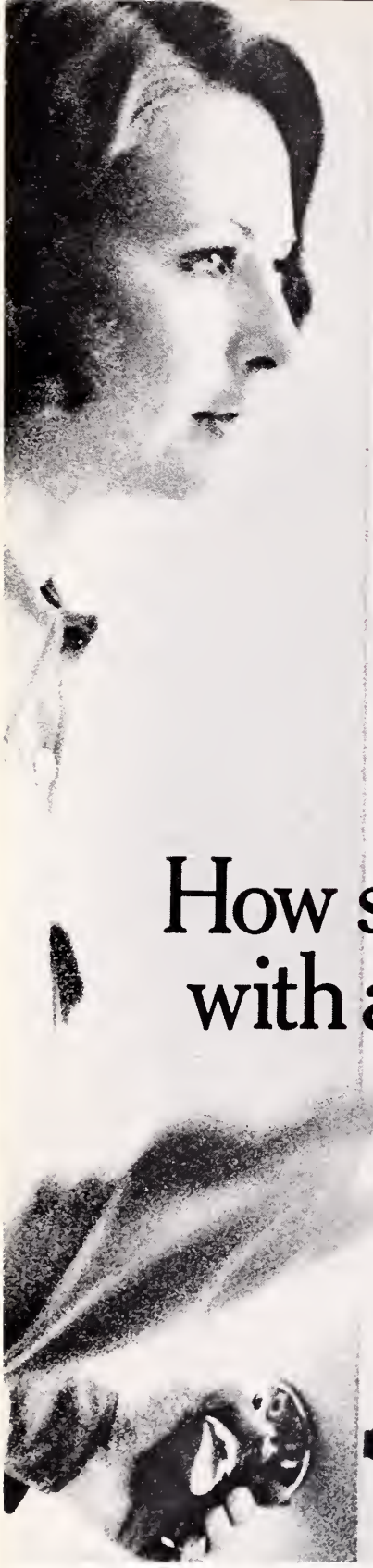
Psychological and Social Rehabilitation

Drug therapy of the seizures is only part of the overall treatment. Attention to the phychological and social needs of the patient must be given by the attending physician. A good number of patients can be controlled with medication and they must be encouraged to lead a normal life, keeping the number of restrictions to a minimum. Patients and relatives must be informed about the nature of the disease and any misconception of the illness must be dispelled. Marriage and bearing children should not be barred although the patient must be advised of the probable higher risk of having affected offspring. When seizures are under complete control, patients may drive an automobile, depending on the reasonable restrictions imposed by most states.

A list of references may be obtained by writing The Journal.

Search for 'Beauty'

THE search for "beauty" has its hazards. A previously unreported complication following breast augmentation with silicone is described in the July 1973 issue of *Archives of Dermatology,* published by the American Medical Association. The case involved a 22-year-old woman who had silicone fluid injected into her breasts to increase her bustline. More than two years later, she developed painful masses in her abdominal wall. The masses, on surgical removal, turned out to be silicone that had "migrated" from the breasts. Wandering silicone has been reported before, but not in that region of the body, the authors wrote.



Success in preventing recurrence of urinary tract infection usually depends on success in treating the initial infection. And that in turn is closely linked to factors of proper drug, proper dosage, and *proper length of therapy*. Much of the effectiveness of an antibacterial agent used to treat an acute nonobstructed urinary tract infection depends, in fact, upon proper length of therapy. As you know, it is potentially hazardous for a patient to discontinue her medication too soon; on the other hand, overtreatment has no advantage and may even cause adverse reactions.

Total therapy: 14 days

Some recent studies suggest that therapy in acute nonobstructed urinary tract infections should be continued for 10 to 14 days even if patients become asympt in 2 or 3 days, as they often After inadequate treatmen course, survival of bacteria cause a quick recurrence o infection.

The problem of persu a patient to complete the fu course of therapy remains cult. Perhaps agreeing on t for a follow-up examination end of medication may be t most effective way of convi a less than enthusiastic pat to continue therapy even af becomes asymptomatic.

As a urinary antibacte Gantrisin (sulfisoxazole) R offers your patient importar vantages, some of which ma increase patient cooperatio

High urinary and plasma l

Therapeutic urinary and pla concentrations are usually

How soon will she drop in with a recurrent cystitis...

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms.
IMPORTANT NOTE: ***In vitro*** **sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections.** Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.
Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.
Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, p or jaundice may be early indication serious blood disorders. CBC and u with careful microscopic examinati should be performed frequently.
Precautions: Use cautiously in pati with impaired renal or hepatic func severe allergy or bronchial asthma. e ysis, frequently dose-related, may c in glucose-6-phosphate dehydroger deficient patients. Maintain adequa intake to prevent crystalluria and st formation.

d in 2 to 3 hours and can be ined on the recommended ;m/day dosage schedule :onvenient for almost all s.

enerally good tolerance

sin (sulfisoxazole) Roche relatively few undesirable ns, and serious toxic re- s are rare. Minor reactions nparatively infrequent, but clude nausea, headache miting. Gantrisin may usu- given safely, even for pro- periods, in the treatment nic or recurrent nonob- ed cystitis, pyelitis or ephritis due to *E. coli* and susceptible organisms. See Important Note in sum- f product information.)

Complete blood counts and urinalyses, with microscopic examination, should be performed frequently.

High solubility

Gantrisin is one of the most soluble of all sulfonamides, with both free and acetylated forms highly soluble in the commonly encountered urinary pH range of 5.5 to 6.5. Urine levels have been detected in 60 minutes; therapeutic levels are usually reached in 2 to 3 hours. About 90% of a single dose is excreted in 24 to 48 hours. As with all sulfonamides, adequate fluid intake must be maintained.

Economy

Average cost of therapy is still only about 6½¢ per tablet.

References: **1.** Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther., 12*:525, 1971. **2.** Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc., 44*: 318, 1969. **3.** Hibbard, L. T., in Bulger, M. J., *et al.*: *Patient Care, 1*:(3)47, 1967. **4.** Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol., 102*:249, 1969. **5.** House, T. E., *et al.*: *Obstet. Gynecol., 34*:670, 1969. **6.** Lampe, W.T.: *J. Am. Geriatr. Soc., 16*:798, 1968. **7.** Moffat, N. A., and Wenzel, J. J.: *Curr. Ther. Res., 13*:286, 1971. **8.** Normand, I. C. S.: *Practitioner, 204*:91, 1970. **9.** Pryles, C. V.: *Med. Clin. North Am., 54*:1077, 1970. **10.** Seneca, H.; Peer, P., and Warren, B.: *J. Urol., 99*:337, 1968. **11.** Trafton, H. M., and Lind, H. E.: *J. Urol., 101*:392, 1969.

if she drops out of her therapy too soon?

For acute, chronic or recurrent nonobstructed cystitis, pyelitis, or pyelonephritis due to susceptible organisms

begin with

Gantrisin®

sulfisoxazole/Roche®

Usual adult dosage: 4 to 8 tablets *stat*, 2 to 4 tablets *q.i.d.*

rse Reactions: *Blood dyscrasias:* ulocytosis, aplastic anemia, throm- openia, leukopenia, hemolytic ane- purpura, hypoprothrombinemia and emoglobinemia; *Allergic reactions:* ema multiforme (Stevens-Johnson rome), generalized skin eruptions, ermal necrolysis, urticaria, serum ess, pruritus, exfoliative dermatitis, hylactoid reactions, periorbital a, conjunctival and scleral injection, osensitization, arthralgia and allergic carditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Supplied: Tablets containing 0.5 Gm sulfisoxazole.

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Breast Cancer: earlier warning system

Futility and frustration beset the physician confronted with breast cancer. For the last 35 years, the survival rate has not significantly changed despite intensive educational programs aimed at earlier detection, and improvement in treatment techniques.

What is the outlook? We know the key to reducing mortality from breast cancer is in the *earliest possible* diagnosis. The stage at which breast cancer is detected is *crucial* to the outcome of treatment. By the time a lump is discovered through BSE or clinical examination, critical time may have been lost.

Mammography

Thermography

And we *do* have the means to achieve earlier diagnosis. We do have an *earlier* warning system. Mammography and thermography can detect breast cancer *before* a lump is discernible by palpation. To demonstrate that it is practical and feasible to detect breast cancer earlier by using these modalities, the American Cancer Society and the National Cancer Institute are funding a network of breast cancer demonstration projects. Supported by grants of $2-million from the ACS and $4-million from the N 20 such centers are expected to be o erative across the country by the e the year. Each will screen at no cha approximately 5,000 women annu in what is considered to be the idea tection program—to include clinica amination, mammography and t mography. Eac these detection m ods contributes in pendently to the de tion of breast can and none can be pensed with in search for early ease.

At present we not prevent bre cancer, but the po tial for saving m lives is immense. five-year survival surges dramatic from 53% when a lary nodes are p tive, to approxima 85% when the dise is localized, to ne 100% for in-situ cancer.

We have an earlier warning syst Let's use it.

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1973 Student Research Convocation West Virginia University School of Medicine

The Eighth Annual Student Research Convocation took place on April 13, 1973. The first prize, an engraved medallion and a $300 cash award, was established in 1965 to honor Dr. Edward J. Van Liere, Dean Emeritus, for his leadership in bringing the School of Medicine to full stature, his devoted interest to undergraduate students and his many scientific achievements. The second and third prizes were $200 and $100, respectively. Publication of the abstracts in *The West Virginia Medical Journal* constitutes important and much appreciated recognition of the students' efforts.

Charles R. Craig, Ph. D., *Chairman*
Student Research Convocation Committee

The Effect of Anesthetics on Non-Polar Compound Solubility in Water

Charles Buffington, Medicine IV

The reason anesthetics reversibly alter the function of many biological systems is not understood, but it is reasonable to propose that alterations in the configuration of constituent macromolecules may be an important factor. Changes in the aqueous solubility of component non-polar subunits of macromolecules does change macromolecules conformation and thereby molecular function. The possibility that anesthetics alter macromolecular function by changing the water solubility of constituent non-polar sub-groups was studied.

Benzene, as a model non-polar compound was equilibrated with degassed, distilled water in the reaction vessel of an evacuated glass manifold held at constant temperature. Aqueous benzene concentration was determined with a closed analytical loop incorporating a flow cell and Carey 17 spectrophotometer. Ethyl chloride or cyclopropane was added in steps to give system pressure of 100 to 700 torr, and benezene concentration measured after equilibration at each step.

Aqueous benzene solubility decreased nonlineraly with increasing ethyl chloride tension: a 46.4+2% decrease occurred at 609+5 torr ethyl chloride. Solubility decreased 12+2% with the addition of 580+5 torr cyclopropane. The U.V. spectrum of benzene remained qualitatively unchanged suggesting that no change occurred in the electronic environment of the aquated benzene molecules.

This phenomenon has not been reported previously to the best of our knowledge. It suggests yet another way anesthetics interfere with cellular function.

A Community Medicine Experience in Rural West Virginia

William Lee Harris, Medicine III

The rural physician has long been a dominant source of leadership in community action. My research has been directed to my role as a leadership force in bringing about needed change in my home community in Nicholas County, the small village of Fenwick (Population: 294). My objectives have been: (1) to identify health and safety hazards in the community, (2) to bring

about public awareness of these conditions, and (3) to seek the participation of government, industry and civic groups in the eradication of these problems.

In order to identify the problems, I surveyed the 95 homes in Fenwick and obtained the opinions of my neighbors as to what areas needed change. The two major problem areas concern flooding and highway hazards. To bring about public awareness, I published a 1,500 word article in the *Nicholas County News Leader* outlining the conditions. In regard to the two major problem areas, I submitted a 24-page report to the U. S. Army Corps of Engineers and a 15-page report to the State Road Commission. In addition, I have met with leaders in government from the Governor on down, with representatives from industry, and with civic groups, seeking their participation in community action.

I am now actively involved in acquiring flood control by extensive dredging of a two and one-half mile reach of Cherry River. I am seeking the necessary funds for $30,000 worth of additional road maintenance to eliminate hazards now being recognized by the road commission. Other areas of community action in which I am involved include development of a two-million dollar public water system, removal of abandoned structures that pose as fire hazards, and encouragement of homeowners in better maintenance of private property.

Electron Microscopy of a Stomach Adenocarcinoma

Patricia Williams, Medicine II

The purpose of this project was to learn the use of the electron microscope along with related techniques and to apply this knowledge to the study of stomach carcinoma. Twenty small blocks were cut from the adenocarcinoma tumor (obtained from the Department of Surgery), fixed and prepared routinely for electron microscopy. Sections were viewed and photographed on an RCA EMU-3C electron microscope (Department of Anatomy).

Five cell types were distinguished and described. Cells of the first type were irregularly shaped and were usually isolated. Most of the cell was occupied by the single nucleus with normally dispersed chromatin. The cytoplasm contained abundant granular endoplasmic reticulum and few mitochondria.

Type II cells were round and associated with a variety of other cell types. They contained multiple, round nuclei with most of the chromatin located peripherally. The cytoplasm contained electron opaque inclusions which in many instances appeared to have condensed away from their limiting membranes.

Type III cells usually were isolated and had single oval nuclei with normal chromatin dispersion. These cells contained scattered mitochondria and numerous membrane-bound cytoplasmic inclusions. These inclusions were more regular in size and shape, and stained to a lesser degree than the inclusions within the Type II cells.

The cells in the fourth group were irregularly shaped with large, pale, irregular nuclei occupying most of the cell. At the periphery of the cells were polyribosomes and numerous large degenerating mitochondria. Generally these cells were found adjacent to other cells of the same type.

Type V cells were larger than the other types of cells. The large pale nucleus contained little chromatin and the cytoplasm was almost devoid of organelles. There were a few scattered mitochondria and occasional strands of granular endoplasmic reticulum. On every occasion that this cell type was seen it was located adjacent to cells similar to Type IV.

No definite correlation of function can be assigned to the cell types; however, Type III cells resemble chief cells, Type IV cells resemble parietal cells, and the granules in the Type II cell resemble the granules in one type of argentaffin-producing cell (Supported by a summer research fellowship from the American Cancer Society).

The Effects of Digitoxin Upon the Cardiac Hypertrophy Of Rats Due to Exposure to Simulated High Altitude

Samuel Kump Roberts, Medicine II

This research problem concerns the effects of digitoxin upon cardiac hypertrophy of rats due to exposure to simulated high altitude.

The experiment involved 100 rats divided into four groups of 25 each: digitoxin-control, digitoxin-altitude, vehicle-control and vehicle-altitude groups. All rats were given daily intramuscular injections of 0.1 ml./100 Gm. body weight with their respective vehicle or digitoxin solutions. Due to digitoxin toxicity, the injections began one week prior to the simulated altitude exposure. During the second week the altitude groups were gradually acclimated to high altitude. In the third week the altitude groups were exposed to 24,000 feet simulated altitude. At the end of the week all the rats were sacrificed. The control groups were exposed to the same conditions other than simulated altitude.

Body weights were obtained because heart weight is a function of body weight. The hearts were then excised—the whole heart was weighed, then the left and right ventricular weights were obtained. Dry weights also were obtained.

Statistical analyses showed that digitoxin significantly reduced the left ventricular hypertrophy in the digitoxin-altitude group but did not prevent the right ventricular hypertrophy at altitude. The digitoxin-control group was not significantly different from the vehicle-control group.

Clinically, the experiment suggests that patients living at high altitudes and who have certain lesions of the left ventricle, might be benefited by the administration of cardiac glycosides.

Experimental Atherosclerosis in Mongrel Dogs

William B. Cline, Medicine II

It is highly desirable to use mongrel dogs for certain experimental studies because of low cost, availability, suitability of size for surgical procedures, and since the ordinary laboratory facilities are geared to their care. Regimens were designed to overcome the mongrel dogs' high resistance to atheroselerosis with some success.

This paper is a part of a larger continuing study concerned with the efficacy of myocardial revascularization in the face of continuing atherosclerosis. Observations concerning the atherosclerosis and serum lipid changes in five animals form the basis of this report.

Methodology — After completion of the revascularization operation, the animal was allowed to recover. Thyroid ablation was then accomplished with I^{131}, 0.5 millicurie/kg. The animals were fed a diet consisting of cholesterol, 20 Gm.; cooking oil, 75 Gm.; cholic acid, 5 Gm. and thiouracil, 2 Gm. added to one to two pounds of dog food daily. Choline, 15 mg. daily, was added empirically to protect against a fatal acute fatty liver degeneration seen in one dog.

The animals were observed for one to eight months and cholesterol (Ch), phospholipids (PL), total fatty acids (TFA), and total lipids

(TL), were measured periodically and an electrophoretic pattern was done at least once on each animal to classify the hyperlipemia according to Frederickson's criteria.

Autopsy findings indicate that atherosclerosis begins to appear at approximately four months and is severe at eight months. The distal abdominal aorta and coronary arteries were the first and most severely involved.

Table 1: Range of Biochemical Data

Dog	Observed	Ch. (mg%)	PL. (mg%))	TFA. (mg%)	TL. (mg%)	Type
1957	Control	147	201	50	550	
2155	1 mo.	1050	350			V
2037	4 mo.	2040-3000	435-550	491-595	6136	V
1983	5 mo.	2150-2820	460-560	333-665	4227-9171	III
1985	7 mo.	950 -2350	402-520	679-810	2960-4700	V
1981	8 mo.	1060-2150	385-515	545-627	2534-3401	V

Investigation of Lipolytic Activities in Tumor Cells

Bernard J. Imrich, Medicine II

The objectives of this study were to obtain a better understanding of the lipolytic activities operative in cancer cells and to contrast their activities with those present in normal cells. Little information is now available on this potentially important metabolic parameter of cancer cells.

Walker Carcinosarcoma 256 in ascites form, maintained by intraperitoneal transfer of cells in rats, were used for this study. Known number of cells (0.5 x 10^8 cells/ml.) were incubated *in vitro* for two hours in a modified Krebs phosphate buffer containing albumin, and the production of free fatty acids (FFA) was measured. The influence of medium pH, of temperature of incubation and of the presence of glucose upon this FFA production was evaluated.

Production of FFA by these cells was linear over a two-hour incubation at 37°C. Two different lipolytic activities were recognized: one with a pH optimum of approximately four and six-tenths and the other with an optimum pH of between seven and eight. Further, these two lipase activities were affected differently by temperature; the acid lipase had a maximal activity at approximately 40°C. and the neutral-alkaline lipase at approximately 34°C. Preliminary studies were conducted in the regulation of these lypolytic activities. As in prior studies with Ehrlich ascites tumor cells (Spector and Steinberg, JLR 7, 657-663, 1966), glucose in the incubation medium inhibited FFA production by the Walker cells at pH 7.4. This inhibition is apparently due to medium pH change as a consequence of lactic acid production from metabolized glucose rather than by increasing FFA esterification.

The presence of acid lipase activity in cancer cells has not been previously reported. The physiological importance of this finding remains to be determined. It may represent a lysosomal enzyme since acid lipase enzymes recently have been identified in lysosomes of normal cells.

A Transit Time Study of Patients with Gardner's Syndrome

Robert Johnson, Medicine II

There are five historical methods of measuring transit time: radiological, colormetric, particulate, chemical and isotopic. There are relative shortcomings in each of these methods. A simple yet accurate technique for measuring transit times has been developed by Hinton, Lennard-Jones, and Young (Gut 10:842-847, 1969) in which barium sulfate filled plastic pellets are used as markers.

Burkitt's transit time studies (Cancer 28:3-13, 1971) have shown that the little refined, high residue diet of the African is associated with a decreased transit time and a very low incidence of bowel cancer. The highly refined, low residue diet of the English is associated with an increased transit time and a high incidence of bowel cancer.

Untreated Gardner's syndrome patients with polyposis coli have a very high incidence of bowel cancer. Transit time studies were done on three Gardner's patients and three control patients. Immediately after defecation the subjects were instructed to swallow 25 barium filled pellets with a glass of water. The next five stool specimens were collected with time of defecation recorded. An x-ray of the five stool specimens was obtained and the time for the passage of the first pellet and for 80 per cent of the pellets was determined.

The results show that the Gardner's patients have a two and eight-tenths times decrease in transit time as compared with the normal control group. The etiology of this decrease is presently obscure. An increased bile salt content in the colon has a cathartic effect and is a factor to be considered.

Ultrastructure Study of the Greene Lymphoma And its Effects on Hepatocytes

Thomas S. Clark, Medicine II

The Greene lymphoma, first described by Greene and Harvey in 1960 (Cancer Res. 20: 1094-1100, 1960), has been the subject of several investigations of an inhibitory influence on metastasis and the immunological basis of tumor immunity. Albrink and Albrink (Yale J. Biol. Med. 43:288-296, 1971) recently reported an associated hyperlipidemia and hepatomegaly in these lymphoma-bearing hamsters.

Light microscopy does not indicate the mechanism of the observed hepatomegaly but ultrastructure observations reveal hypertrophy of smooth endoplasmic reticulum, decrease in glycogen, and increase in cell size. Ablation of the tumor, after changes in the hepatocytes had been observed, failed to produce regression of the induced hepatocellular changes.

Ultrastructure observation of the tumor reveals two different virus particles. Virus particles replicating from the cell membrane and observed in extra-cellular spaces were identified as C-particle virus and have not previously been described in this lymphoma. Virus particles budding from the rough endoplasmic reticulum into the intracisternal spaces have been described in this tumor as well as other tumors. Attempts to induce tumor with sonically disrupted cells were successful but attempts to induce tumor with ultrafiltrates of this homogenate failed.

The relation between the hyperlipidemia, the hepatocyte ultrastructure changes, nonregression of these changes after ablation of the tumor, and tumor-virus particles will be discussed.

Special Article

Podiatry Service in a Suburban Hospital*

(A Three-Year Review)

John T. Sharp, D. P. M.

THE Abington Memorial Hospital is a 500-bed general hospital located in the northern Philadelphia suburbs. It is a modern, well equipped, efficiently staffed health care complex serving a community of 230,000 people. The staff is comprised of 235 medical practitioners.

For a number of years the hospital had conducted a podiatry clinic under the direction of the late A. T. Ross, D.P.M. This was purely an outpatient clinic, but it offered a medium through which the economically underprivileged could obtain adequate foot care.

In 1968 under the direction of Alfred S. Frobese, M.D., chief-of-staff and director of the surgical division, and Robert M. Packer, Jr., M.D., physician-in-chief of the metabolic and endocrine disease service, steps were initiated for the organization of a formal podiatry service. In essence this was to be an extension of podiatry into the realm of inpatient care, as well as a sophistication of the existing outpatient podiatry clinic. The creation of this new facility was for the purpose of offering expanded health care in an area which is often inadequately considered or largely neglected.

Many hospitals throughout the nation are considering the addition of a podiatry service to their available accommodations. This delineation of the functions of such a service at Abington Hospital is intended to assist those involved in such planning.

The podiatry service at Abington Memorial Hospital presently consists of five practicing podiatrists, all graduates of schools recognized by the Council on Education of the American Podiatry Association. In accordance with the by-laws of the staff, all podiatrists must be legally licensed to practice podiatry in Pennsylvania and must be members of, or eligible for membership in, a duly recognized podiatry society (By-laws, Abington Memorial Hospital Medical Staff, Article III, Section 5).

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The Author

- **John T. Sharp., D. P. M., Podiatrist-in-Chief of the Podiatry Service, Abington Memorial Hospital, Abington, Pennsylvania; also a Member of the Editorial Board of the Journal of the American Podiatry Association.**

Structurally, the podiatry service is a division of the department of surgery. The podiatrist-in-chief- of the service is "responsible to the governing board of the hospital through the director of the department of surgery, and the chief-of-staff for the functioning of his division. . ." Initial application for membership to the staff in the area of podiatry is made to the podiatrist-in-chief. Subsequently, the applicant's credentials are presented sequentially to the director of the department of surgery, the executive committee of the staff, the chief-of-staff, and finally to the board of trustees. Formal appointment is made by the board.

Once appointed to the hospital staff, the podiatrist is entitled to conventional staff privileges. Members of the podiatry service are governed by the laws of the medical staff and must conform to the rules and regulations of the staff. They must also adhere to the rules and regulations of the podiatry service.

The function of the podiatry service is to provide comprehensive foot care to the hospital's inpatient and outpatient community. This is accomplished through the following mechanisms.

Consultation Service for Inpatients

Members of the podiatry service are required to serve as consultants in instances where inpatients require foot evaluation and/or foot care. Such consultations are requested by members of the medical or surgical staff and are avail-

able to both private and teaching patients. A written consultation report for the patient under consideration is the responsibility of the consulting podiatrist, and such reports are incorporated in the patient's hospital chart.

Outpatient Foot Clinic

The podiatry service also has the responsibility of maintaining an outpatient podiatry clinic. This presently functions on a one-morning-per-week basis. Its purpose is to offer efficient, active and preventive foot care to those individuals economically unable to afford private office fees. Attendance in the clinic is mandatory for all podiatry staff members. In the first thirty months of operation, the podiatry clinic had a total of 1,159 patient visits. This represents approximately 2.4 per cent of the total patient visit load of all the outpatient clinics operational in the hospital. In evaluating these statistics, the fact must be considered that, as previously stated, the podiatry clinic functions only one morning each week, whereas some of the other outpatient clinics operate on a multiple-day-per-week basis.

TABLE 1

	1969	1970	1971	Totals
Digital arthroplasties	22	29	30	81
Metatarsal head remodeling	3	6	8	17
Excision plantar neuroma	4	2	5	11
Exostectomy	3	8	0	11
Radical nail surgery	0	4	6	10
Sesamoidectomy	1	5	1	7
Bunionectomy	10	18	26	54
Excision neoplasms	7	6	21	34
Total	50	78	97	225

Foot care by the podiatry service is preventive as well as active. All new diabetic patients in the metabolic clinic are required to receive a complete foot evaluation by a member of the podiatry staff. In addition, all outpatients seen in the clinic who are suffering from diabetes mellitus or vascular insufficiency are given printed instructions as to the proper home care of the foot in such disorders. The podiatry clinic also offers actual exposure to the management of foot problems for students from the school of nursing. Such students have periodic observational assignments to the clinic. To supplement this teaching practice, lectures are given the nursing students relative to nursing care in foot problems.

Inpatient Care for Private Podiatry Patients

Members of the podiatry staff have the privilege of admitting patients to the hospital for inpatient medical or surgical care. Such admissions are on a combined podiatric-medical/surgical service. Once admitted, the patient's general medical care is the responsibility of the physician, while his foot care is in the jurisdiction of the podiatrist. In this hospital, patients who are to be admitted for podiatric surgery usually have their preoperative histories and physicals, as well as their necessary laboratory studies, performed on a preadmission basis. The patient is given a history and physical form by the podiatrist, which is presented to the admitting physician at the time of his examination. Such evaluations are performed within one week prior to scheduled surgery. The completed history and physical form and a surgical consent form are taken by the patient to the hospital at the time of his admission. These records, together with his preadmission laboratory reports, are then incorporated into the hospital chart.

Podiatric Surgery

Since podiatric surgery seems to be one of the more prevalent concerns of hospitals considering the establishment of a podiatry service, it would seem in order to dwell briefly upon this aspect of podiatry care as it has functioned within the hospital environment at Abington.

In any consideration of podiatric surgery within a hospital patient community, there are certain basic factors relative to the practice of podiatry which must be understood. Primarily one must realize that for the great majority of podiatrists, foot surgery constitutes only a part of the total practice responsibilities. Thus it becomes apparent that podiatric surgical admissions represent but a portion of the podiatrist's private patient census. Further, most of the surgical procedures performed by the podiatrist are applied to the forefoot and may be done either on an outpatient basis or an inpatient basis requiring a short hospital stay. The following statistics will serve to highlight these statements.

Short Procedures Unit

In early 1970 Abington Memorial Hospital initiated a short procedures unit—a facility tailored for outpatient surgery which, although not requiring actual hospital stay, was nevertheless not suited for office practice because of anesthesia requirements or the need for specialized equipment. Since the advent of this unit, 35 per cent of all podiatric surgery has been performed via short procedures. During the three years of operation of the podiatry service, a total of 128 surgical patients have been admitted, either as inpatients or as outpatients in the short procedures unit. On this group, 225 surgical procedures have been performed. The inpatient segment of the group had an average hospital stay

of 4.8 days. The nature of the surgical procedures performed upon podiatric patients—both as in-patients and out-patients—is indicated in Table I.

A survey of podiatric surgical procedures reveals that they involve a minimum expenditure of available hospital time.

Today's podiatrist is a well educated, clinically trained member of the health team. His prepodiatry requirements consist of a minimum of two years of college education, although in actual practice approximately 80 per cent of the present applicants to podiatry colleges have baccalaureate degrees. The educational tenure in the podiatry college consists of four years during which the student is trained in the basic, clinical, and medical sciences. The faculties and facilities of the podiatry schools compare quite favorably with those of the various other educational institutions involved in teaching the health sciences. In many instances, faculty members serve concomitantly on the teaching staffs of local medical schools. In several states, local law requires that the podiatrist serve a one-year residency prior to initiating practice.

The foot is an extremely complex structural and functional unit. It requires highly skilled and specialized care. The podiatrist, by virtue of his concentrated academic and clinical training in the area of foot health, is better qualified than any other member of the health team to offer this care. But the foot is a part of the body as a whole, and as a consequence a number of foot abnormalities are not purely local phenomena but rather are pedal reflections of systemic disease. It is thus evident that truly total foot management must often be a coordinate effort on the part of the podiatrist and other medical personnel. The hospital should be an environment where such care is available.

Addendum

Recent years have seen an increasing emphasis on an amalgam of allied health professionals in a hospital setting cooperating for the benefit of the sick and injured. This philosophy has been applied to podiatric medicine in our hospital.

As noted, this service previously was an outpatient facility largely used by the indigent patients in the clinic. Physicians and surgeons assumed little interest in the problems of the foot, and with the exceptions of the care administered by the orthopedic surgeons, this area seemed neglected. The development of an inpatient podiatric service has made the podiatrist an effective member of the health care team. By his availability for consultation, physician interest in disorders of the foot has been stimulated. The initiation of podiatric surgical procedures in the operating suite has made another service available to our community without imposing a burden on our facilities—since the majority of such procedures are either carried out in the short procedures unit as outpatient situations or performed on inpatients and require only a brief hospital stay. Furthermore, development of inpatient podiatry stimulates the podiatrist to higher levels of performance, since the creation of such a section carries with it certain standards of care which must be followed and obligations to the hospital and its staff which must be met. In our hospital this has resulted in the generation of a sense of pride of membership on the part of the podiatrist which has, I believe, even upgraded the outpatient podiatry clinic.

In short, our experience with a structured podiatric service with inpatient and outpatient privileges represents an advance in health care —and where today's well-trained podiatrist is available, a community hospital should find little, if any, problems in developing such a section. A service of this type should prove advantageous to both.

Alfred S. Frobese, M.D.
Chief-of-Staff
Director of Surgical Division
Abington Memorial Hospital

Special Article

Recruitment of the West Virginia Medical Graduate: Recognition and Approach to the Problem

Thomas S. Clark and Michael J. Lewis

Introduction

ACTIVE discussion about the obligations and responsibilities of the West Virginia University School of Medicine in the role of providing physicians for the State is again manifest. Discussion of this problem has been heard in both the political and educational arenas with experts in all aspects of politics, education and health care delivery systems expressing opinions and alternate solutions to the problem.

Unfortunately, little, if any consideration has been given to those who will be most intimately involved. This group, the medical students, may also contribute some feasible approaches to entering and providing a health care system within this State that is both practical and attainable.

The Responsibility and Obligation Of The Medical Student

The responsibilities of the medical student may be greater than those in other professional schools or in that respect, even the paramedical professions. By virtue of the present approach used in the practice of medicine, the future physician will usually serve as a team leader, and all too often will be the sole responsible party in providing health care to a large segment of people.

Aside from the great responsibility of obtaining as much fundamental medical knowledge as possible in the four years of study, the medical student must learn how to apply the greater part of this knowledge, often in less than ideal circumstances. This is particularly true if one chooses to practice medicine where larger medical facilities or referral centers are not readily accessible or available.

One of the greatest future responsibilities for the medical student is to maintain a sense of reality as to what services he can offer personally, and what services he can offer his patients by the appreciation of and collaboration with services offered by the medical school or other medical centers.

The Authors

- **Thomas S. Clark and Michael J. Lewis, Third-Year Medical Students, West Virginia University School of Medicine, Morgantown.**

Obligation of the Medical Graduate

The obligation of the medical graduate to serve the State is no greater than it is for any recipient of a State funded educational program. This would include recipients of bachelor degrees as well as other professional training programs. To put this in further perspective, there is no great outcry for the retention of paramedical professionals. In large part, this may be due to the lesser demand for these skills, but demand does not dictate obligation.

The only moral recourse the State has in recruitment of physicians is to instill into the medical student the desire to express a sense of gratitude for this educational opportunity. This, therefore, should be the grassroots of recruitment.

The Responsibility and Obligation Of The Medical School

The medical school's primary obligation, as an integral part of the University, is to provide quality medical education. Quality, as opposed to quantity, in the educational process, has always been a hallmark of good education.

This is not to say that the medical school does not have a responsibility to the State to select those students whose social background would be compatible with a practice within the State.

This responsibility is partially met by recognizing, as candidates for entrance, the undergraduate academic qualifications of the State residents educated in State schools as well as out-of-state institutions. Such procedure provides qualified students and at the same time meets a further responsibility to the State to educate its resident's children.

Similarly, the medical school's admission committee has a responsibility to the taxpayers to choose the student body from individuals that have demonstrated ability to meet the academic challenge of medical school. To accept individuals merely on their apparent sincerity is doing an injustice to the many individuals who have competently met the challenge of four years of an undergraduate curriculum.

Impressionable Freshmen

First-year medical students are by and large an enthusiastic and impressionable group. Generally, these attributes are desirable, but this impressionability may often have a somewhat less than useful aspect.

The students are amazed by astute clinicians with their array of diagnostic and therapeutic judgment, skills and equipment. During the subsequent years of medical school, students continue to be exposed to this same high caliber medicine. There is no implication that this is wrong, but many students do graduate thinking that good medicine can be practiced only with advanced specialty training and within the confines of an elaborate medical facility.

This trend is enhanced by the failure of many students to be aware of and to appreciate medicine as practiced by many outlying physicians.

In order to maintain principles of good education, specialty subjects should be taught by experts in each field. Unfortunately, the enthusiasm demonstrated by these teachers for their specialty combined with the impressionability of the student often leads to a premature decision on the part of the medical student. By the end of the second year most students no longer are faced with decision between family practice and another specialty, but only which other specialty to choose.

Grassroot Recruitment

Regardless of the establishment of a family practice program at West Virginia University, the recruitment of family practitioners for the State cannot be expected to be limited to these select few. Recruitment should start on the day of acceptance into medical school. The physician or other community leader who recommended the student, and his county and state medical societies should all play an organized and integral role in influencing and convincing this student to practice in the State.

Some Practical Suggestions

There are numerous approaches to the recruitment of physicians for West Virginia. The following represent some practical suggestions that the medical as well as the lay community of the State may wish to consider.

— The continuing contact by local physicians with encouragement to the student(s) to visit their practices on his holidays, weekends and vacations. This should be done in a manner which does not appear as a token gesture.

— Wives of practicing physicians and community leaders can have an influence by exposing students' wives to the advantages and satisfactions of community practice and living.

— The provision of financial aid by county medical societies or communities which can be repaid by practicing in the area. This should not be repaid by practicing at less than a competitive income.

— The de-emphasis on the academic level that specialties are of a paramount importance, and the realization that resident training program procedures and practices are not always realistic in the small community.

— The recognition that not all communities are equally attractive to the physician and *his family*. Because of a lack of certain essentials such as adequate educational facilities and personnel, many communities have difficulty in recruiting any type of professional.

— A continued support and encouragement of opportunities such as the senior selective program whereby students establish State contacts by spending a portion of their senior year in community hospitals with practicing physicians.

— Greater attempts at recruitment of West Virginia residents attending medical schools out-of-state.

— Encouragement of recent graduates to practice general medicine in small towns and rural areas for a few years before entering specialty training.

— More community hospitals participating in medical education and advanced training programs, and to insure that the experiences and benefits are competitive with those of neighboring states.

Summary

The preceding comments are not meant to de-emphasize the importance of teaching by specialists or specialty training, including family medicine, but rather to emphasize that a reasonable balance between family practitioners and other specialists is both desirable and attainable.

Achievement of such a balance and encouragement of all specialists, including family practitioners, to remain in the State would be a realistic step toward meeting the health care needs of the people of West Virginia.

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Charleston, West Virginia

8 P.M. Friday, January 18
10 A.M. and 2 P.M. Saturday, January 19
10 A.M. and 1:30 P.M. Sunday, January 20

THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY EVENING, JANUARY 18, presentations will include Professional Standards Review Organizations (PSROs) and a session open to the public on the "battered child." A medically oriented battered child program will follow SATURDAY MORNING, JANUARY 19, with these other scheduled subject areas: SATURDAY AFTERNOON, diabetes, heart disease and hypertension; SUNDAY MORNING, JANUARY 20, cancer chemotherapy, drug interactions and arthritis; and SUNDAY AFTERNOON, chest disease, obstetrics and gynecology, urology and venereal disease control.

THE FACULTY will include outstanding specialists in their fields from various educational and other settings, both outside and from within West Virginia.

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M.D., and Joseph T. Skaggs, M.D., both of Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents; and will include admission to a group buffet luncheon on Sunday, January 20. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Practice.

OVERNIGHT ACCOMMODATIONS: Physicians planning to spend one or more nights in Charleston should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters inn setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. Va. 25324.

Please register me for the Seventh Mid-Winter Clinical Conference in Charleston, W. Va., January 18-20, 1974. My $15 registration fee is (is not) enclosed.

I will attend sessions at 8 P.M. Friday, January 18 ..... 10 A.M. Saturday, January 19 ....., 2 P.M. Saturday ..... 10 A.M. Sunday, January 20 ..... 1:30 P.M. Sunday ..... all sessions .....

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A message from . . .

The President

HERE WE GO!

By now you should have recovered from the Annual Meeting just completed at The Greenbrier. The Program Committee has already had its first meeting and plans are underway to equal if not excel this year's program. Mark the dates August 21-24, 1974 off your calendar now.

Speaking of program committees, I thought this year's program was simply magnificent. Lest you think this an immodest remark let me quickly assure you that this Program Chairman did very little. Bill Lively and the headquarters staff did the major portion of the work and Bill Carter, Dick Daniel, Bob Janes, Phil Sprinkle and Hugh Wiley were the idea and contact men in rounding up our distinguished speakers.

One of the advantages of practicing medicine in West Virginia is the good fortune we enjoy in having The Greenbrier as the site for our Annual Meeting. The skill, hospitality and all-round pizazz of the staff—as well as the beauty of the setting are rare qualities to be cherished when found.

I would be remiss if I failed to commend Worthy McKinney for the outstanding leadership he has provided our Federation this past year and let me quickly add his will be a tough act to follow.

One final thought—the next year promises to be a most difficult and trying one. We must at all cost maintain our unity and present a united front to those who would divide us. The one recurring theme you will find on this page this year will be unity. Through unity we can assure our patients that their best interests will be served and they will continue to receive the best medical care in the world.

Tom McCoy

A. Thomas McCoy, M. D., *President*

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EDITORIALS

ANOTHER LOOK AT THE DOCTOR SHORTAGE IN WEST VIRGINIA

Elsewhere in this issue (page 261) is an article by Clark and Lewis, medical students at the West Virginia University School of Medicine, on the general topic of medical practice in West Virginia. Some of the practical suggestions have been advanced by the West Virginia Chapter of The Student American Medical Association and its members for years; others are applicable to faculty only. The story is probably representative of the student viewpoint, and is an interesting analysis of why we lose, and how we may retain WVU graduates.

In April 1968 *The Journal* published an article by Dr. Jack Pushkin, showing that an untapped pool of mature and trained specialists in residency at the WVU Hospital was lost to the State by apathy. These two essays should be read by all members because the recommendations therein are quite applicable to our present dilemma. The doctor shortage has been discussed exhaustively, but the Clark and Lewis study is our first dialogue with the student body.

There is a firm demand that all concerned parties put forth more effort to keep a larger proportion of our graduates at home. Legislators have recommended procedures that would make it mandatory for all graduates to practice at a specified place for a stated number of years. We know all such schemes are unworkable and unworthy. Really, West Virginia's problem is no worse than other states, and this issue is not unique to West Virginia. We must remember there is great movement and reciprocity of physicians throughout the land. We gain annually a significant number of doctors who were educated outside the State and at no State expense. Many of them are West Virginia residents returning to their home for practice. We also license scores of foreign graduates annually, but at this time, our special pitch is for our own graduates. We want them to stay at home and we assume responsibility for finding for them satisfactory competitive practice in West Virginia.

The doctor shortage is nationwide, but is especially grave in sparsely populated areas. The recent blast for family physicians should not obscure the fact that West Virginia is woefully short of physicians in all specialties and subspecialties, except general surgery. Many patients will have more confusion in getting the proper specialty appointments than they will in securing general medical care. Specialty medicine is here to stay and will become more narrow as medicine becomes more complex. So let's not get lopsided in our demands.

The doctor shortage has been a prime topic of discussion for presidents, council, house of delegates and executive office for years, even prior to the establishment of our four-year

School of Medicine. We think the matter has been fully explored until a resident or student awakens us to new horizons. The services of county societies, executive office and *The Journal* are open to all inquisitive graduates or residents.

Mr. William H. Lively, Executive Secretary, recently sent a personal communication to all 1973 graduates—giving top priority of his office to all requests for information and services (The text of the letter is published following this editorial).

Any survey of medical needs in the USA will indicate such essentials are being met as rapidly as medical schools can be established or can increase their enrollment. There are now many schools for physician assistants. Nursing schools are developing in almost every college, and it is probable that overall needs will be reasonably met within the next five years; but the clamor for medical care is now. With improvement in communication, new community and area hospitals, a competent and well trained ambulance service, the situation is not now as deplorable as some "authorities" indicate. But surely, at no time, will immediate care be available to every person, for every ailment, in every hollow, at every hour.

The article of Mr. Clark and Mr. Lewis should be read, by all our members, and any doctor who has a solution or plan that will help us retain the interest of student and resident is requested to write *The Journal* and divulge his thoughts on the subject.

With all parties — students, residents, WVU-SMA, legislature, press and public — now showing a feverish interest in the doctor shortage problem, it is the plea of *The Journal* that this dialogue with the student body may be continued.

Perhaps a special committee of our Association, devoted solely to this purpose, with representation of students, residents and faculty might spark a solution.

To Members of The 1973 Class
West Virginia University
School of Medicine:

We hope by this time you and your families have adjusted to the new surroundings and responsibilities following your graduation from the West Virginia University School of Medicine in May. We offer to you sincere congratulations upon completion of your four years of hard work prior to receiving the Doctor of Medicine degree.

The officers and members of the West Virginia State Medical Association want you to know that we sincerely look forward to the day you complete your internships, residencies, service obligations, etc. Why? Because you are wanted and needed in West Virginia—and there are many fine practice opportunities waiting for you in communities throughout the State.

The West Virginia State Medical Association and the headquarters office in particular have made recruitment of WVU graduates our Number One priority.

Most of you are familiar with the State and have a good idea concerning the need for physicians in various areas; if not—then drop us a note or call "collect" (304) 346-0551. We'll lay aside our routine assignments with the Legislature, The Journal, PSRO details and the like to give you a helping hand.

We're sure you are aware of the need for additional family physicians and specialists in West Virginia. We have helped a large number of WVU graduates find a good place to practice and raise their families. We can do the same for you—if only you give us the chance.

Please keep in touch with us and the WVU School of Medicine. We are working together as a team to bring our graduates back to the State. We have a great deal to offer and completion of the Interstate and Appalachian Corridor System will bring us closer together. We also are arranging postgraduate sessions which will keep you right up-to-date in the field of continuing medical education.

We are aware some of you will be ready to enter practice in July 1974. Great! We're here to be of assistance and we know your friends and family physicians in your home communities will do the same. To those of you who plan to move on into residencies or service obligations—don't forget us. Please keep in touch. We want you and your families back with us to take care of the health care needs of the citizens of West Virginia.

Let us hear from you!

With every good wish and warm personal regards, I am,

Sincerely,

William H. Lively,
Executive Secretary

In our apprehension over the moon-bound cost of living indicators, it is reassuring to note that the cost of remaining among the living, in one major respect, at least, has gone down. While other items in health care costs have gone steadily up, drug costs in many instances have actually gone down. To confirm this all one has to do is to compare price lists of today and of 20 years ago.

PHARMACEUTICAL FRIENDS

The drug industry, too often the target of undeserved Naderesque criticism, is too seldom recognized for this economic feat and for other contributions to our health care system. Medicine's newest magic is occasionally a new device, a new tool, or a new technique but most often it is a new drug.

We hear so much about government research grants that we tend reflexly to regard government as the sole source of medical good things, the sole research benefactor of the suffering sick. We are inclined to overlook the enormous investment in research as well as in production facilities by drug companies. In addition, they finance a substantial educational effort to promote the most effective use of their remarkable new products.

This latter contribution, that of educating doctors in the uses of new drugs, is one which enriches and in a very practical way promotes the goals of continuing education programs. In the 1973 AMA Membership Opinion Poll more than one-half of those polled acknowledged the positive influence of pharmaceutical representatives. In return for this service, the drug industry is abused and vilified by consumer advocates for thus "advertising" their products. The well-mannered, well-informed, bright and engaging young pharmaceutical representatives ill fit the picture of snake-oil and herb-root medicine show hucksters one could expect from descriptions of their alleged activities. Nor is it too flattering to doctors to be pictured as country bumpkins being taken in by the slick knavery of these drummers.

At the risk of appearing self-serving, we call your attention and commend to you those drug firm advertisers who regularly grace the pages of this and other medical journals. Here, as in any publishing venture, the advertisers pay a substantial portion of the costs. They, in effect, subsidize the scientific and educational endeavor carried on in these pages. This endeavor, after all, was the original and remains the chief reason for this Journal's being.

In the face of persistent criticism of our system of medical care, it is our responsibility to proclaim loudly what is good and praise-worthy in our system. The pharmaceutical industry fits these criteria. A free, independent and competitive drug industry is essential to a progressive and economical system of health care. Under the guise of consumer advocacy we have seen partially successful attempts to stifle a free and independent drug industry. These efforts have had an antithetical effect in that by this advocacy consumers have repeatedly been denied the healing and salving benefits of drug discoveries for years after the rest of the world has safely enjoyed their use.

The traditional relationship of trust and respect between the physician and the apothecary is one which finds no impediment today. We share mutual interests and opportunities as well as mutual problems. Our individual and collective futures are bound tightly together. We are fated to endure a series of abrasive encounters with government at all levels in the years immediately ahead. For our part we should be prepared to support our pharmaceutical friends at every opportunity.

Recently a stimulating article by Dr. Evalyn S. Gendel appeared in *The Journal*[1] which concerned fatigue and fitness in women. Stress was laid on the many complaints some women register about their health. The point made by Doctor Gendel is that women should pay much more serious attention to physiologic fitness. She mentioned one observation which is particularly pertinent, namely that the more physiologically fit group had less of all the common complaints, menstrual discomfort, backache, digestive disorders, fatigue, colds and allergies.

WOMEN: FITNESS AND FATIGUE

Unfortunately women are often spoken of as the "weaker sex." This is not true. In many respects she is physically heartier than men. It is well-known, for example, that women live longer than men; they also seem capable of withstanding high blood pressure better than men, indeed some women live for years with a marked elevation of blood pressure and appear to get along fairly well. They also withstand pain better than men.

Basic research has been done on the ability of rats to withstand acute oxygen want. It has been observed that female rats are capable of withstanding severe degrees of acute hypoxia significantly better than male rats. Whether this latter point applies to human beings is, of course,

questionable; but nevertheless it is an interesting observation.

Since women are not physiologically the "weaker sex" it is quite logical that she should maintain herself in good physical condition. Younger women could be counseled to take rather vigorous exercise, such as playing golf and tennis, swimming, horseback riding, and even jogging. Older women probably would be interested in less arduous exercises, but could be encouraged to do gardening, take long walks or play a leisurely game of golf. These are only a few suggestions and it is likely that her physician could make many more.

All this is true if she is not burdened with heavy household duties or the care of children. Many older women, of course, often do but little housework and their children are away from home. It is these women especially who are more likely to complain of some of the many symptoms outlined by Doctor Gendel. It is possible that at times too much stress may be laid on the physiologic value of exercise. On the whole, however, there appears to be a general agreement that an individual feels better if exercise is taken.

In summary, it would appear that physicians should give thoughtful consideration to the suggestions made by Doctor Gendel. As she emphasizes "a tired complaining, cross, female companion, date, wife, daughter, boss, or friend is no joy to anyone." She offers good evidence that, in a measure at least, many of the symptoms of which some women complain, can be avoided or greatly alleviated, if they pay more attention to physiologic fitness.

---

1. E. S. Gendel (69: 112, May, 1973)

MEDICAL STUDENT RESEARCH CONVOCATION

The ninth annual Medical Student Research Convocation was held April 13, 1973. The students reported the results of researches they had performed under the direction of their teachers during the year. Eight papers were reported.

The abstracts of papers which appear in this issue of *The Journal* have a definite scientific value; indeed, some of them have important clinical applications. Presumably it is safe to say, however, that the greatest value of the work is the effect on the students themselves. They learned the arduous methods of scientific research and the tedious and painstaking labor involved; moreover, they observed the value of statistical analysis, but most relevant of all the importance of the inherent intellectual honesty associated with scientific investigation.

It is to be hoped that their brief introduction to scientific research will be of lasting benefit to them. It is possible that in some instances the students will be provoked later to perform independent research, but perhaps this is too much to expect of them because of their relatively brief training period. However, the investigative work which they performed should always stand them in good stead. As a result of their experience in medical research they have become even more aware of the significant use of their critical faculties. This will aid them greatly, not only in clinical diagnostic procedures, but also in evaluation of medical literature which they will peruse so long as they practice medicine.

MAYNARD P. PRIDE, M.D. (1914-1973)

The death of a physician and a community and state leader of the caliber of Dr. Maynard P. Pride leaves all of us without words or actions to properly express our sadness.

No matter what yardstick we might use to consider the contributions of this man, we find him measuring up to the highest standards we can set.

Whether we think of Doctor Pride as a physician and surgeon, as a civic leader, as a friend, or as a willing partner in anything that might serve to improve his city, his state or his country, we can only despair of finding another to take his place.

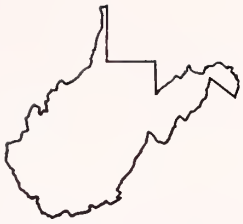
Doctor Pride had the rare gift of doing everything well, whether it be a delicate operation or a stint as a volunteer for a charitable fund drive. Not many men with his busy schedule, his great talent and his high standing would have consented to take the difficult and thankless job of United Fund campaign chairman; Maynard Pride did that and did the job exceedingly well.

His professional achievements are known to most West Virginians; they are almost legendary. He was, in fact, scheduled to preside at an important technical session at the West Virginia Medical Association convention later this month.

Those who will perhaps miss him, most, aside from his fine family, will be the thousands of people who depended on his professional skill to heal and to save. For them, there will be no adequate replacement.

All of us will be poorer in many ways. We join his immediate family in shock and in mourning, even as we console ourselves with the fact that we've all been so much better off because Maynard Pride did spend so many years with us.—*The Dominion-Post* (*Morgantown*).

GENERAL NEWS



Added Evening Sessions Scheduled For Next Clinical Conference

A Friday evening program, including a public session on the "Battered Child," will be added to the format of the Seventh Mid-Winter Clinical Conference to be held next January 18-20 in Charleston at the Heart-O-Town Motor Inn.

C. A. (Carl) Hoffman, M. D.

Hartwell G. Thompson, M. D.

In addition, a concurrent session on Professional Standards Review Organizations (PSRO's) will be held during the new Friday evening program. Physicians will choose which session they desire to attend.

The annual conference is sponsored by the State Medical Association in conjunction with some of its component medical groups and volunteer health organizations. Formerly held as a one-day Conference on Chest Diseases, it was expanded to a two-day program last January in keeping with a goal of fewer but bigger and more inclusive meetings in continuing medical education for the State's physicians. Drs. Ralph H. Nestmann and Joseph T. Skaggs of Charleston, who again are serving as Co-Chairmen, said the Friday evening agenda was added in a continuing effort to meet this goal and as a result of the favorable reception by physicians to the expanded program last January.

The "Battered Child" theme will continue in a panel discussion Saturday morning as the scientific sessions begin. Prior to this session, Dr. Charles A. (Carl) Hoffman of Huntington, immediate Past President of the American Medical Association, will deliver welcoming remarks.

Scheduled for Saturday afternoon are a paper on diabetes and presentations by Dr. Ray Gifford from the Cleveland Clinic, Department of Hypertension; and Dr. E. Gordon Margolin, Director of Internal Medicine at Jewish Hospital in Cincinnati.

Dr. Hartwell G. Thompson, Dean of the Charleston Division of the West Virginia University School of Medicine, will preside at the scientific sessions on Sunday morning.

Scheduled to date for the Sunday morning session are Dr. Raymond B. Weiss, WVU Medical Center; and Dr. Irving Kushner, the new Chairman of Rheumatology at the WVU Medical Center. A speaker on "Drug Interactions" also is being planned for this session.

Dr. Clair Cox, Professor of Urology at the University of Tennessee, will be among the speakers being scheduled for Sunday afternoon. Papers on obstetrics and gynecology, chest diseases and venereal disease control also are expected to be presented that afternoon.

A $15 registration fee for the Conference will cover the traditional Sunday noon buffet luncheon and some of the other expenses.

Additional details will be provided in later issues of *The Jounal* as the program takes final shape.

Occupational Health Congress Set For Philadelphia

The 33rd Annual Congress on Occupational Health will be held September 17 and 18 in Philadelphia at The Benjamin Franklin Hotel.

Russell B. Roth, M. D., President of the American Medical Assocaition, will deliver the keynote address.

Discussion topics will include "Occupational Safety and Health After Two Years," "Chest Radiology in Occupational Pulmonary Diseases," "Workmen's Compensation a Year Later," "Antidiscrimination in Employment of Women," "Priorities in Preventive Medicine — Where Are the Highest Yields?," "Rehabilitation Nursing in Florida," and "Diagnosis of Occupational Disease in General Medicine."

The Conference is co-sponsored by the AMA Department of Environmental, Public, and Occupational Health; American College of Radiology; and National Institute for Occupational Safety and Health, U. S. Department of Health, Education, and Welfare.

Two New Doctors Named At Mental Hospitals

Two new doctors have joined the West Virginia Department of Mental Health, filling vacancies created by the resignations of clinical directors at two State mental hospitals.

Jorge V. Ottaviano, M. D., has been appointed Clinical Director at Huntington State Hospital and Marianito Montero, M. D., M. P. H., at Lakin State Hospital. Doctor Ottaviano comes to the Department from Northville State Hospital, Northville, Michigan. He was born in Paraguay and received his M. D. from the Medical School of the University of Asuncion, Paraguay. Doctor Ottaviano was staff psychiatrist at Spencer State Hospital from 1957-66. He replaces Dr. Jaime Lazaro as Clinical Director at the Huntington hospital. Doctor Lazaro will enter private practice at Clarksburg.

Doctor Montero will replace Dr. Margaret T. Ross at Lakin, who is retiring after serving eight years with the Department. Doctor Montero, formerly with Weirton General Hospital, received his M. D. from Manila Central University and his M. P. H. (with emphasis on mental health) from Johns Hopkins University.

Doctor Ross also was employed by the West Virginia Association for Mental Health, the Kanawha County Board of Education, and as Acting Clinical Director and Acting Superintendent at Lakin. She also served as Acting Director of the West Virginia Department of Mental Health for several months.

Hypnosis Seminar In Morgantown

A seminar in medical-dental hypnosis will be held September 7-9 in Morgantown at the Lakeview Inn and Country Club. The seminar is sponsored by the West Virginia Society of Clinical Hypnosis in cooperation with the West Virginia University Department of Psychiatry and the American Clinical Society of Hypnosis.

Both beginner and advanced courses will be given. Application has been made for continuing education credit from the American Academy of Family Physicians. For further information contact Susan Gustke, M. D., 4315 Emerson Avenue, Parkersburg 26101.

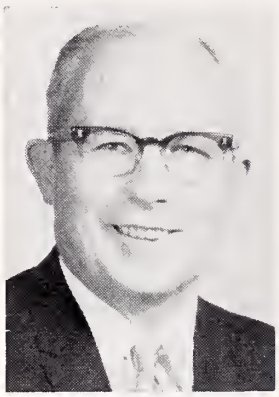
Dr. Bofill Appointed At Hopemont State

Dr. Rano S. Bofill has been appointed Clinical Director at Hopemont State Hospital (Preston County). Doctor Bofill, a native of the Philippines, is a graduate of the University of Santo Tomas in Manila. He formerly was a staff physician at Mercy Hospital in Columbus, Ohio; Bryce Hospital, Tuscaloosa, Alabama, and Appalachian Regional Hospital, Hazard, Kentucky.

Hopemont State, under the Department of Public Institutions, treats primarily the chronically ill and aged.

Dr. Maynard P. Pride Dies at Age 59

Dr. Maynard P. Pride of Morgantown, a Past President of the West Virginia State Medical Association and one of the most active members of the organization, died suddenly on August 6 in Philadelphia where he had attended a meeting of the National Board of Medical Examiners the previous two days.



Maynard P. Pride, M. D.

Doctor Pride was 59 years old at the time of his death and had practiced his specialty of surgery in Morgantown for the past 27 years.

A native of Belpre, Ohio, Doctor Pride attended the public schools in that community before enrolling in Marietta College where he was graduated in 1935. He received his M.D. degree in 1939 from Western Reserve University Medical School in Cleveland and interned at University Hospital in that city, 1939-41. He remained there for his residency in surgery until 1946, when he moved to Morgantown and began the private practice of surgery with his uncle, the late Dr. C. B. Pride.

See Editorial on Page 263

Doctor Pride was certified by the American Board of Surgery in 1955 and through the years he was closely associated with the West Virginia University School of Medicine, holding the faculty rank of Clinical Professor of Surgery at the time of his death.

From the beginning of his practice in Morgantown, Doctor Pride became active in organized medicine on the county, state and national levels. He served as Secretary and President of the Monongalia County Medical Society and served two terms as a member of the Council of the State Medical Association. He was elected Vice President of the Association in 1967, President Elect in 1968 and was installed as President in 1969. He served as Chairman of the Association's Council after his term as President.

Doctor Pride was Chairman of the Program Committee for the Association's 1972 Annual Meeting and had served as Chairman of the WVU Liaison Committee since 1971. He also served as a member of the Nurses Liaison Committee, the Committee on Medical Education and Hospitals and the Resolutions Committee.

He was appointed to the Medical Licensing Board of West Virginia in 1966 and recently was elected a Director of the Federation of State Medical

Boards on the national level. He was a member of the American Medical Association, American College of Surgeons, Southern Medical Association and the Southeastern Surgical Congress. In 1971 he served as Chairman of the United Fund Campaign in Monongalia County and was a member of the Board of Directors of the First National Bank of Morgantown.

Doctor Pride is survived by his wife, the former Sue Randall; three daughters, Amy and Heidi, both at home, and Mrs. Janet Anderson of Houston, Texas; two sons, John B. Pride of Atlanta, and Robert M. Pride of Morgantown; his father, Eber Pride of Belpre, Ohio; and four grandchildren.

He was preceded in death by his first wife, Frances Barnes Pride; his mother, Amy Bradley Pride; and one brother, Russell Pride.

Medical Education Seminars Set By Wheeling Clinic

"Sub-Clinical Thyroid Disease" will be the topic of the next bi-monthly Wheeling Clinic Medical Seminar to be held on September 12 at Wilson Lodge, Oglebay Park, Wheeling. The speaker will be Dr. Frank M. Mateer of Pittsburgh, according to Dr. Rizal V. Pangilinan, Education Committee Chairman for The Wheeling Clinic.

Doctor Pangilinan said the final continuing medical education seminar for the year will be "Diabetes and Diabetic Retinopathy," November 14, with Dr. Neva P. Arribas of St. Louis, Missouri as the speaker.

The seminars are held as dinner meetings. Those interested in attending are requested to contact Doctor Pangilinan in advance at The Wheeling Clinic, Eoff at Sixteenth Street, Wheeling 26003.

WVU School of Medicine Greets Class of '76

Seventy-eight West Virginians and six residents of four other states have begun their first year at the West Virginia University School of Medicine.

Selection of a class grows more difficult each year for the school's 12-member Committee on Admissions. The 84 students were chosen from a total of 2,013 applications (an increase of 288 over last year). Interviews were granted to 285 West Virginians and 93 non-resident applicants.

Grade point average for the accepted candidates was 3.45 with a science average of 3.48.

Members of the new class completed their undergraduate work at 34 different institutions—24 out-of-state and 10 in West Virginia. Less than half (39) attended WVU.

Among the accepted candidates are one graduate from the United States Naval Academy and one from the Air Force Academy.

(Continued on page 273)

Dr. W. P. Bittinger Honored By Oak Hill Rotary Club

Dr. W. P. Bittinger of Oak Hill was honored recently when he was presented the distinguished service award by the Oak Hill Rotary Club during the annual ladies' night banquet.

Dr. W. P. Bittinger of Oak Hill recently was presented with a "distinguished service award" by the Oak Hill Rotary Club. Shown above are, left to right, Doctor Bittinger, the Rev. Shirley Donnelly, Mr. George Jones and State Sen. Pat R. Hamilton.

Presenting the award to Doctor Bittinger were the Rev. Shirley Donnelly and Mr. George Jones, President of the Rotary Club. Mr. Jones remarked that the Club took a special delight in presenting the award in the form of a plaque which was inscribed to Doctor Bittinger "for devoted, unselfish and significant devotion to the Rotary and to the growth and betterment of the community."

State Sen. Pat R. Hamilton was program chairman for the evening and the guest speaker was Earl M. Vickers of Montgomery, Director of the West Virginia Legislative Services Department.

Dr. and Mrs. Bittinger also attended the 50th anniversary of his graduating class at the Medical College of Virginia in Richmond.

During his fifty years in practice Doctor Bittinger has been an active member of the West Virginia State Medical Association and served two terms as a member of the Council. He also served for many years as a member of the Medical Licensing Board and is a Past President of the West Virginia Tuberculosis and Health Association and the Fayette County Medical Society.

New VA Hospital Director

Albert M. Blecich, 43-year-old official in the Veterans Administration's central office in Washington, D.C., has assumed new duties as Director of the VA Hospital in Huntington.

Mr. Blecich was Director of the Management Analyst Service in the VA's Department of Medicine and Surgery before succeeding Dr. Lucius L. Powell, who retired last March, in Huntington.

AMA Council Issues Statement On Venereal Disease

The following statement on venereal disease was issued on July 23, 1973 by The Council on Enviromental, Occupational and Public Health of the American Medical Association:

Gonorrhea ranks first (excluding influenza) and syphilis third among the reportable diseases in the United States. During 1972, there were 767,215 gonorrhea cases reported, 14.5 per cent higher nationally than the previous year and more than double the number reported in 1965. Increases have occurred in all parts of the nation and in all age and sex groups, but the largest concentration of cases is in the 15-24 year age group. Allowance for both under reporting and failure to diagnose all cases as they occur suggests that the actual occurrence of gonorrhea infection last year was about 2.5 million.

The Center for Disease Control estimates that the reservoir of gonorrhea includes 6 to 800,000 females and about 100,000 males that are asymptomatic. To help reduce this reservoir of silent carriers, most states have implemented gonorrhea screening programs for females. The Center for Disease Control reports that from July 1972 to March 1973 there were 3,117,022 females screened and 158,604 (5.1 per cent) had a positive test for gonorrhea. Of 664,110 females tested in private physician offices throughout the nation, 2.5 per cent had a positive culture for gonorrhea. The Council urges medical societies to promote gonorrhea culture screening among females.

During 1972, syphilis morbidity (all stages) exceeded 91,000 reported cases. The number of congenital syphilitics under one year of age numbered 383 in 1972. Reported cases of primary and secondary syphilis (the infectious stages) numbered 24,429, up 3 per cent from the previous year, with an estimated 85,000 cases occurring annually. Because large numbers have escaped detection over the years, it is estimated that if every person in the United States could be tested for syphilis today, about ½ million previously untreated cases would be found.

An important procedure used to identify persons infected with syphilis or gonorrhea is laboratory reporting to public health authorities of those who have a positive test for either. The patient is contacted through his own physician for diagnosis and treatment if necessary. The following states do not have laws or health department regulations that require laboratories to report persons with positive VD tests to health authorities: Alaska, Idaho, Indiana, Louisiana, Maine, Massachusetts, North Dakota, South Dakota and Washington.

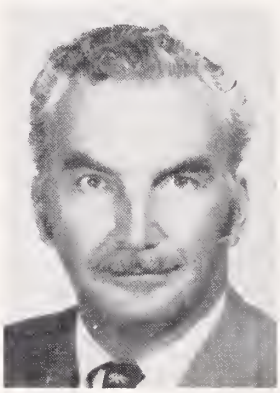
Experience has shown that many laboratories refuse to report persons with a positive test for venereal disease to the health department until it is required by law or regulation. The Council rec-

(Continued on page 274)

Program Completed For Heart Assn. Meeting In Charleston

The Annual Meeting of the West Virginia Heart Association will be held September 14 and 15 in Charleston at the Heart-O-Town Motor Inn.

The theme of the scientific sessions will be "Hypertension," with emphasis on epidemiology, diagnosis and treatment.



Harold Selinger, M. D.

Alvin P. Shapiro, M. D.

Registration will begin on Friday, September 14, at 1 P. M. Also scheduled for Friday afternoon will be a meeting of the General Assembly, at 2 P. M., and displays and demonstrations of equipment. There will be a dinner, entertainment and dancing Friday night.

Harold Selinger, M. D., President of the Heart Association, will preside at the General Assembly. The keynote address will be delivered by Michael E. Wilson, M. D., Professor and Chairman of the Department of Physiology and Biophysics, West Virginia University School of Medicine.

Saturday will be devoted to both scientific and lay sessions, with an Awards Luncheon at noon. Robert J. Marshall, M. D., Past President of the Heart Association, will be the guest speaker at the luncheon and will present Volunteer Awards.

At 3:30 P. M. on Saturday, the General Assembly will reconvene. Recommendations from the scientific session and the non-medical discussion groups will be made and new officers will be installed.

The Annual Board Banquet and Meeting will be held Saturday night.

Leo H. T. Bernstein, M. D., Vice President of the Heart Association, will welcome physicians to the scientific sessions on hypertension Saturday morning. William H. Carter, M. D., of Charleston, will preside. The speakers and their topics will include:

"End Organ Involvement in Hypertension"—Robert C. Tarazi, M. D., Department of Medicine, Cleveland Clinic Foundation;

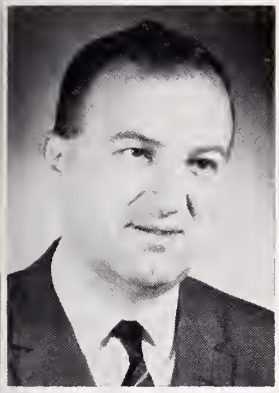
"Hypertensive Screening in Washington, D. C."—Mrs. Ellen L. Hathaway, R. N., Administrative Assistant to Dr. Frank A. Finnerty, Jr., M. D.,

Professor of Medicine at Georgetown University Medical Division;

"Current Drug Treatment of Hypertension"—Alvin P. Shapiro, M. D., Dean, School of Medicine, University of Pittsburgh;

"Diagnostic Evaluation of the Hypertensive Patient—Cost Benefit Analysis"—J. Caulie Gunnells, Jr., M. D., Professor of Medicine, Duke University Medical Center.

The program for the lay volunteers also will be on hypertension and will run concurrently with the scientific sessions.



Robert J. Marshall, M. D.

William H. Carter, M. D.

WVU School of Medicine

(Continued from page 271)

Also entering the School of Medicine will be twin brothers from Dunbar, James and John Brick. Both were undergraduates at WVU.

Ten women and two black students are among the accepted candidates.

Members of the class include:

BERKELEY COUNTY—Davis Hall Shingleton of Gerrardstown.

BOONE COUNTY—Robert Burton Atkins, Danville.

BRAXTON COUNTY—Roger Kyle Westfall, Flatwoods.

CABELL COUNTY—David M. Baughan, George John Linsenmeyer, III; Paul Samuel Meade, Robert Allen Nuzum and Jack Richard Traylor, Jr., all of Huntington.

CLAY COUNTY—Richard Tom Sizemore, III, Clay.

FAYETTE COUNTY—James Michael Beane and Thomas Edward Blume, Fayetteville.

GILMER COUNTY—John Junior Templeton, Glenville.

GRANT COUNTY—John Sanford Veach, Petersberg.

GREENBRIER COUNTY—Stephen Lowell Sebert, Fairlea; and Thomas Forrest Mann, Lewisburg.

HAMPSHIRE COUNTY—D. Gregory Bott of Rio.

HANCOCK COUNTY—Louis Steven Chaldares and Gregory Mark Haines, Weirton.

HARRISON COUNTY—Terence Michael Cone and George William Shehl, Clarksburg.

JACKSON COUNTY—David Alan Denning, Ravenswood.

KANAWHA COUNTY—Larry Keith Cantley, Big Chimney; Jerry Walter Froelich, Cabin Creek; Robert Edwin Gunnoe, Michael Bennis McBride, Chris Wesley McGary, James Enoch McJunkin, Lawrence Matthew Minardi, Elizabeth Starr Parkin, Scott Kirschner Radow and David Owen Wright, all of Charleston; James Emmerson Brick and John Franklin Brick, and Jack Willard Smith, Jr., Dunbar; Darrel Keith Quick, Elkview; Winston Churchill Evans, Montgomery; David Howard Johe, Robert Mark Jones and John Franklin Kessler, South Charleston; James David Adams and Richard Austin Wallace, St. Albans.

LOGAN COUNTY—John Robert King, Jr., Cora; and Rhonda Kay Brennan, Sarah Ann.

McDOWELL COUNTY—Ronald Benjamin Dalton, Gary; William Marshall Mentz and Virginia Susan Villani, Welch.

MARION COUNTY—Blake Ramage Boggess, Paul Edward Frye, Keith Charles McLaughlin and Forrest Wayne Smith, all of Fairmont.

MERCER COUNTY—Michael Allen Fiery, Katherine Ann Huffman, Eugene Raymond Kidwell, Jr. and David Joseph Larkin, all of Princeton.

MONONGALIA COUNTY—Edward Lee Emch, Mrs. Pamela Marian Fawley, Richard Domenick Gais, Sidney Boggess Jackson, Norman Edward Kowal, Richard Andrew Orr, Timothy Gerhart Saxe, John Romildo Vanin and Matthew Bruce Vukoson, all of Morgantown.

MORGAN COUNTY—Kevan Phyllis Andrews and James Doyle Helsley, Berkeley Springs.

OHIO COUNTY—Donald Louis Powell, Triadelphia; and Thomas Brent Hokanson, Wheeling.

PENDLETON COUNTY—Donald Fred Teter, Franklin.

RALEIGH COUNTY—Mary Han Lee and Michael Angelo Luchini, Beckley; and Amabile Milano, Sophia.

RANDOLPH COUNTY—Marjorie Lynn Bush and George Henry Dornblazer, Elkins.

RITCHIE COUNTY—Terry Lynn Elliott, Smithville.

WAYNE COUNTY—Paul Alex Blair, Kenova.

WETZEL COUNTY—John Herbert King, New Martinsville.

WOOD COUNTY—Fred Timothy Kerns, Parkersburg; and Wayne Boyd Cayton, Jr., Vienna.

Members of the class from out-of-state are:

Steven Lloyd Diehl, Hagerstown, Maryland; John Henry Mani, Canton, Ohio; Denise Therese Kalinowski, McKeesport; Ronald Orian Valdiserri, Monongahela; and Timothy Bruce Hetzer, Nottingham; all of Pennsylvania; and John Edward Golay, Hampton, Virginia.

AMA Council

(Continued from page 272)

ommends that medical societies in these states take appropriate action for the enactment of laws or regulations that require laboratories to report the positive venereal tests.

With the exception of Wisconsin, all the states now have laws or regulations permitting the treatment of minors for venereal disease without parental consent. It is believed, however, that some of the states' laws and regulations are so worded to make them inadequate. Also, some of the states might improve their laws by broadening the age group definition of minors.

Physicians in private practice treat approximately 80 per cent of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea they treat. Physicians should assist public health departments by reporting the venereal disease cases they treat. Medical societies are urged to cooperate and give broad support to public health authorities.

Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea. Most state and some local health departments have venereal disease interviewer-investigators who can work confidentially with the patient and his contacts to determine the source and spread of his infection. The Council urges the physicians to utilize the services of these trained investigators.

Adequate therapy of veneral disease, using the right forms and dosages of antibiotics, is essential. Neisseria gonococci has shown the ability to develop resistance to penicillin to the point where the recommended dosage now is 4.8 million units of Aqueus procaine penicillin for the treatment of gonorrhea in both males and females. It is anticipated that additional changes in treatment may have to be made from time to time as increasing resistance becomes a problem or more effective antibiotics are discovered. For this reason the Council urges that medical societies impress upon their members the need for keeping abreast of changes in the recommended therapy of the venereal diseases.

The Council encourages the publication of more articles in professional journals on venereal disease and its control for the guidance of the profession. Medical societies are asked to support education of parents and the public through more extensive and imaginative use of all available media and through school curriculum.

The Council urges medical societies to acquaint their membership with the growing and alarming dimensions of the venereal disease problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Sept. 6-8—Am. Assn. Ob. & Gyn., Hot Springs, Va.
Sept. 14-15—W. Va. Heart Assn., Charleston.
Sept. 15-16—Am. Assn. Oph., Dallas.
Sept. 16-20—Am. Assn. of Med. Clinics, L. A.
Sept. 16-20—Am. Acad. of Oph. and Otol., Dallas.
Sept. 17-18—AMA Cong. on Occupational Health, Philadelphia.
Sept. 17-20—Ky. Medical, Louisville.
Sept. 19-23—Pa. Med. Society, Phila.
Sept. 20-23—Am. Soc. Internal Med., Dallas.
Sept. 27-29—Natl. Conf. Cancer of Colon & Rectum, Bal Harbour, Fla.
Sept. 29-30—AMA on Alcoholism, Pocono Manor, Pa.
Oct. 1-4—AAFP, Denver.
Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 7-11—Am. Soc. Anesth., San Francisco.
Oct. 10-13—Pa. Med. Society (Scientific), Harrisburg.
Oct. 15-19—ACS Clinical, Chicago.
Oct. 17-21—Eastern Orthopaedic Assn., White Sulphur Sprgs.
Oct. 18-21—Med. Soc. of Va., Norfolk.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.
Oct. 21-26—Am. Acad. Physical Med. & Rehab., Washington.
Oct. 22-24—Am. Coll. of Gastro., L. A.
Oct. 26-28—Pot.-Shen. PG Institute, Martinsburg.
Oct. 31—Nov. 1—Am. Assn. Study of Liver Diseases, Chicago.
Nov. 4-8—Assn. Am. Med. Colleges, Wash.
Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-9—Am. Cancer Society, New York.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-12—Am. Assn. Cancer Educat., Honolulu.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.
Nov. 14-17—Am. Acad. of Neuro. Surgery, Pasadena.
Dec. 1-4—Am. Sec. Hematology, Chicago.
Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.
Dec. 3-5—So. Surg. Assn., Hot Springs, Va.

1974

Jan. 18-20—Mid-Winter Clinical Conf., Charleston.
Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.
Jan. 19-24—Am. Acad. Ortho. Surgeons, Dallas.
Jan. 25-27—So. Rad. Conf., Point Clear, Ala.
Jan. 25-27—AMA Natl. Leadership Conf., Chicago.
Feb. 11-14—Am. Coll. Card., N. Y.
Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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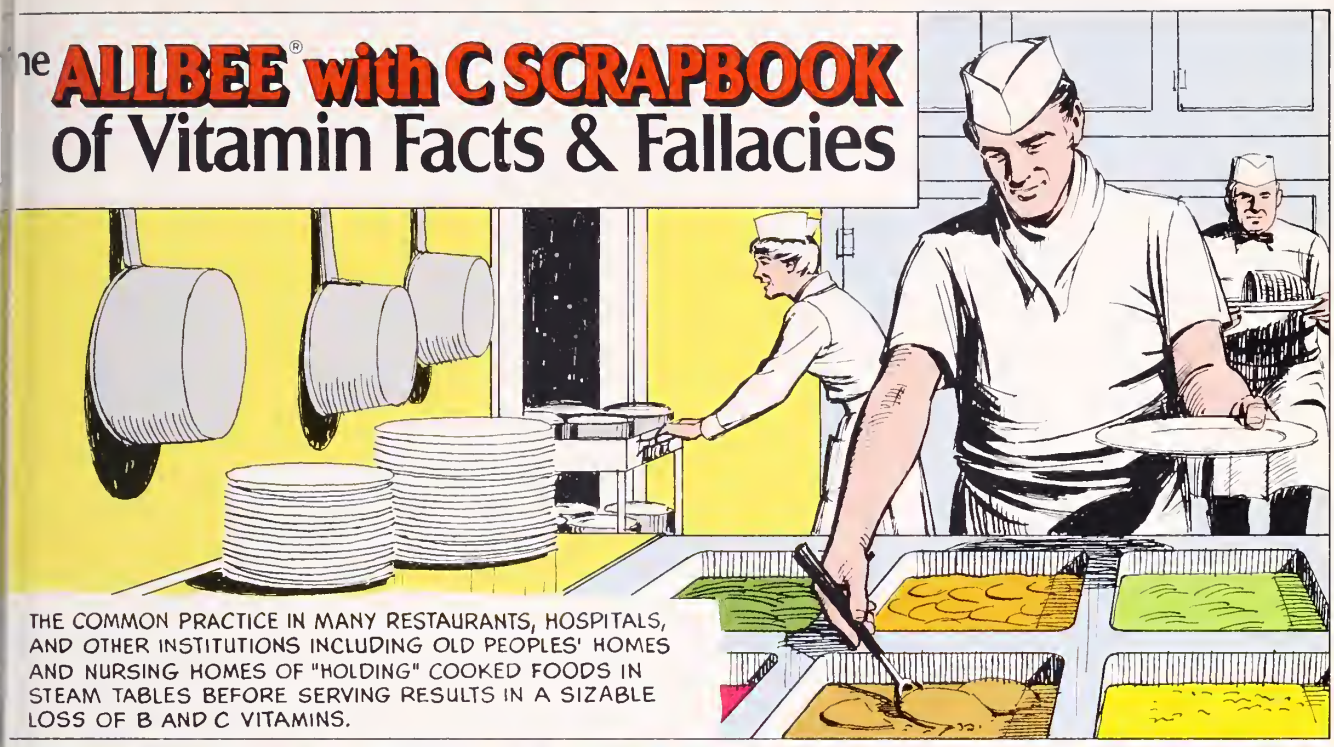
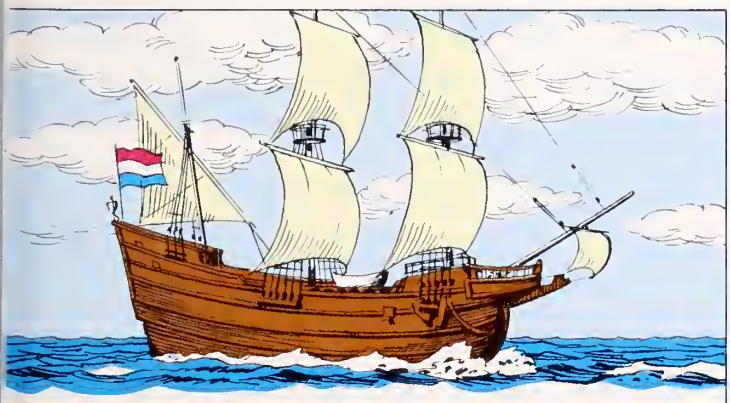


THE COMMON PRACTICE IN MANY RESTAURANTS, HOSPITALS, AND OTHER INSTITUTIONS INCLUDING OLD PEOPLES' HOMES AND NURSING HOMES OF "HOLDING" COOKED FOODS IN STEAM TABLES BEFORE SERVING RESULTS IN A SIZABLE LOSS OF B AND C VITAMINS.

DURING THE CIVIL WAR 30,714 CASES OF SCURVY WERE REPORTED, AND 383 DEATHS WERE ATTRIBUTED DIRECTLY TO THE DISEASE.

THE AMOUNT OF SUNLIGHT AVAILABLE DURING RIPENING DETERMINES TO A LARGE EXTENT THE FINAL ASCORBIC ACID CONTENT OF TOMATOES. HENCE, A COOL, WET SUMMER PRODUCES WATERY, LESS TASTY FRUIT THAT'S LOWER IN VITAMIN C.



RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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atropine sulfate	0.0194 mg	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg
phenobarbital	(¼ gr.) 16.2 mg	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg.
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Society	President		Secretory		Meetings
Boone	David E. Wallace	Madison	Harold H. Howell	Madison	2nd Wed.
Brooke	John W. Traubert	Wellsburg	James E. Wise	Follansbee	
Cabell	Thomas F. Scott	Huntington	Charles H. McKown, Jr.	Huntington	2nd Thurs.
Central West Virginia	Clemente Diaz	Richwood	Joseph B. Reed	Buckhannon	As Sched.
Eastern Panhandle	Hiram Sizemore, Jr.	Shepherdstown	Everett S. Fogle	Martinsburg	2nd Wed.
Fayette	W. B. Davis	Rainelle	Ivan H. Bush, Jr.	Oak Hill	1st Wed.
Greenbrier Valley	John J. Yaeger	Wht. Sul. Springs	Herbert L. Pope	Wht. Sul. Springs	2nd Wed.
Hancock	Dominic A. Brancazio	Weirton	James M. Garvey	Weirton	3rd Tues.
Harrison	Robert D. Hess	Bridgeport	Ray A. Harran	Bridgeport	1st Thurs.
Kanawha	George W. Hogshead	Nitra	G. A. Shawkey	Charleston	2nd Tues.
Logan	Thomas P. Long	Man	J. J. San Pedro	Man	2nd Wed.
Marion	Robert R. Frye	Mannington	John C. Turner	Fairmont	Last Tues.
Marshall	Andrew J. Barger	Glen Dale	Daniel B. Gordon	Glen Dale	3rd Tues.
Mason	Aaram Boonsue	Pt. Pleasant	Antonio G. Sola	Pt. Pleasant	4th Tues.
McDowell	John S. Cook	Welch	Emilio Delgado	Welch	2nd Wed.
Mercer	A. J. Paine	Bluefield	John J. Mahood	Bluefield	3rd Mon.
Mingo	Charles H. Bruce	Williamson	Wm. H. Carter	Williamson	2nd Wed.
Monongalia	Margaret I. Stemple	Morgantown	H. Summers Harrison	Morgantown	1st Tues.
Ohio	Stephen D. Ward	Wheeling	Donald H. Hofreuter	Wheeling	4th Tues.
Parkersburg Academy	Lyle D. Vincent	Parkersburg	James M. Carter	Parkersburg	1st Thurs.
Potomac Valley	James C. Bosley	Piedmont	Carl A. Liebig	Keyser	2nd Wed.
Preston	Thomas A. Haymond	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	James A. Gardner	Beckley	R. James Yates	Beckley	3rd Thurs.
Summers	Jack D. Woodrum	Hinton	P. A. Ballista	Hinton	3rd Mon.
Tygart's Valley	S. M. Santibanez	Grafton	A. Kyle Bush	Philippi	3rd Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	N. Martinsville	Monthly
Wyoming	Francisco Flores	Mullens	S. D. Readica	Mullens	Quarterly

WVU Medical Center
–News–

• Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

THE appointment of a director of obstetrics and gynecology for the Charleston Division of the West Virginia University Medical Center has been announced by WVU President James G. Harlow.

Dr. Robert Dunbar Patchell, who will be in charge of the academic programs for medical students and house officers in the Charleston Division, also holds the appointment of Professor of Obstetrics and Gynecology at WVU.

"Doctor Patchell will develop programs in close cooperation with the department in Morgantown," said Dr. Hartwell G. Thompson, Dean of the Charleston Division.

"We believe that the resources of the Charleston Division of WVU and the Charleston Area Medical Center, when combined with the resources of the Department of Obstetrics and Gynecology at West Virginia University Medical Center in Morgantown, will provide an excellent training experience for medical students taking their required courses in obstetrics and gynecology, elective courses, and for officers at different stages in their training," he added.

Doctor Patchell received his premedical and medical education at the University of Toronto in his native Canada and also served his internship and residency in surgery in that country.

He spent 11 years in private practice in Saskatchewan Province with the exception of one year spent in London, England, in obstetrics-gynecology training at the Royal Postgraduate Medical School at Hammersmith and Edgware General Hospitals. After one year as a Fellow in Pathology at the University of Western Ontario, he resumed his residency in obstetrics and gynecology at Victoria-London Hospital in Ontario and at Harlem Hospital Center in New York City.

Prior to his present appointment, Doctor Patchell had been on the staff of Harlem Hospital for eight years and held faculty appointments at Columbia University College of Physicians and Surgeons. During the last year, Doctor Patchell was Acting Director of Obstetrics and Gynecology Services.

A Fellow and Certified Specialist of the Royal College of Surgeons of Canada, he is a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetricians and Gynecologists and the American College of Surgeons.

WVU Hospital Promotes Tiano

John T. Tiano, a native of Clarksburg, recently was promoted from Assistant Director to Associate Director of West Virginia University Hospital.

Recipient of the E. J. Van Liere Award, a gold medal and a check, William L. Harris won first place at West Virginia University School of Medicine's student research convocation for his thorough report of "A Community Medicine Experience in Rural West Virginia." Now a senior, Harris conducted his project in Fenwick, his home town. (See abstract of Harris' paper on page 253).

Tiano's administrative functions, with emphasis on fiscal and patient relations, include direct responsibility for patient registration and hospital systems development.

Eugene L. Staples, Director of University Hospital, said, "I'm delighted to be able to have a man of John Tiano's caliber and background as Associate Director. In the brief time he has been on the staff many changes have taken place that are particularly important in view of external pressures from third parties and government for new reporting mechanisms and accountability."

Before he assumed his WVU Hospital post Tiano was associated with hospitals in Harrison, McDowell and Logan Counties. He received a bachelor's degree in pharmacy in 1957 from WVU and a master's in hospital administration in 1970 from the University of Minnesota, serving his residency for his M.H.A. at WVU Hospital.

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The Month in Washington

In an effort to reach some hard conclusions in the fuzzy area of the impact of various kinds of health insurance on health care, the federal government is starting a $30 million experiment.

Some of the questions that researchers hope to answer are:

—Would erasure of all financial barriers cause a surge of demand?

—Do deductibles and co-insurance exert a brake on frivolous or excessive use of physicians and hospitals?

Do families alter their patterns of physician-hospital utilization depending upon their type of insurance? How is their health affected?

Five-Year Health Insurance Study

The study, handled by the Office of Economic Opportunity (OEO) in conjunction with the Health, Education, and Welfare Department, will cover 2,000 families containing about 7,500 people. It will last up to five years. About 100 families in Dayton, Ohio, will be enlisted shortly. Four other cities eventually will take part. The participants' identities are confidential.

The HEW Department is slated to take over the project next year. Noting the proposals before Congress for national health insurance (NHI) programs, the OEO says "The federal government will inevitably play a major role in determining the way in which the nation's health insurance plans operate. Unfortunately, current knowledge of health economics is not sufficient to predict the effects of public policies related to health insurance."

Those in the experiment will have to give up existing health insurance policies. New ones will be provided free as far as policy cost is concerned. The coverage will take three basic forms:

(1) No deductible; no co-insurance. Basically unlimited free medical care.

(2) $100 yearly per-person deductible, no co-insurance.

(3) No deductible, 20 percent co-insurance.

There will be variations on these plans. But all will have a catastrophic provision above a certain amount of out-of-pocket costs determined by some fraction of the yearly family income.

Findings To Guide National Program

Officials concede that Congress may enact a NHI bill before much meaningful data is accumulated from the experiment. Nevertheless, they say, the information will be valuable and could lead to adjustments in any existing national program.

- **From the Washington Office of the American Medical Association.**

Benefits will vary in the experimental plans. One will cover all visits to physicians' offices while the patients share hospital costs. Psychiatric care will be limited to 50 outpatient visits annually. Dental care will be confined to children and exclude orthodontic work.

Families of all income levels will be included, up to $25,000 a year. All participants will be interviewed in depth; about one-third will receive physical examinations.

The experiment is being conducted under a grant to the Rand Corporation, Santa Monica, California; a subcontract for operational work is held by Mathematica, Inc., of Princeton, New Jersey.

No one will be surprised if some commonly-held notions aren't exploded when the project is finished. A little-publicized HEW study, for example, indicates that average costs per medical visit are much cheaper with the private practitioner than at a neighborhood health center or a pre-paid group practice. The estimated private costs ranged from $6.58 to $10.63 by specialties. In contrast the cost per visit at 18 well-established neighborhood health centers was $21.16. The pre-paid group rate was figured at more than $18.

The report, prepared by the office of the Assistant HEW Secretary for Planning and Evaluation, said that strict comparisons among the three modes of delivery are difficult and subject to interpretation. Yet "the order of magnitude difference was far greater than had been anticipated."

Taking into account all variables, the report said "When related to the estimated private practice average cost per visit the (neighborhood) center physician encounter cost appears to be extreme in nature."

On the surface, through the study group took pains not to put it so bluntly, the report indicated that larger delivery systems might not be as efficient and economical as the solo practitioner.

The report concluded:

"Like any analysis, this study raised questions which others must examine and answer. Unfortunately, the luxury of time to answer these questions is not available. As we move through a period of rapid social and health policy change the need for these answers become almost immediate."

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Obituaries

JOHN S. BOLING, M.D.

Dr. John S. Boling, an anesthesiologist who practiced in Calhoun County from 1946 to 1955, died at his home in Lubbock, Texas, July 4. He was 56.

A native of Burkes Garden, Virginia, Doctor Boling received his M.D. degree from the George Washington University College of Medicine in Washington, D.C., and interned at Charleston General Hospital. He operated the Boling Clinic in Grantsville.

He was a former member of the Parkersburg Academy of Medicine and the West Virginia State Medical Association. Doctor Boling is survived by his widow; a son, John, and a daughter, Susan, at home; and a second daughter, Mrs. Tyler Dennis, of Lubbock.

* * * *

OLIVER H. BRUNDAGE, M. D.

Dr. Oliver H. Brundage, Parkersburg internist for more than 25 years, died suddenly on July 23 in a hospital there. He was 56.

Doctor Brundage was affiliated with the intern and resident doctor program at St. Joseph's Hospital in Parkersburg for the past 16 years and directed the extern program initiated at the hospital in 1972. He came to Parkersburg in 1947 and practiced for some time with Dr. William R. Yeager. He also served as physician for the local U. S. Naval Reserve Center.

Doctor Brundage was a graduate of Duke University and received his M. D. degree in 1942 from the Temple University School of Medicine. He completed his internship and residency at Bryn Mawr (Pennsylvania) Hospital. He was a member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association and its committees on Medical Aspects of Sports and Tuberculosis, the American Medical Association, and the American Diabetic Association. He was one of the founders of Kno Koma, a summer camp for diabetic children at Clendenin (Kanawha County). He served as a Commander in the U. S. Navy during World War II.

Doctor Brundage introduced rowing to the secondary school system in the Parkersburg area in 1961 and had been active in this program until his death.

He was the founder and President of the Ohio Valley Rowing Club, served as team physician for the U. S. Rowing Team in Ontario, Canada in 1970 and 1971; was appointed Chairman of the National Association of Amateur Oarsmen Development Committee; was a licensed NAAO National Rowing Referee, a member of the NAAO Board of Directors and Chairman of the Medical Committee.

Doctor Brundage was born in Upland, Pennsylvania and received his early education in Chester, Pennsylvania.

Survivors include the widow; one daughter, Mrs. Barbara Chapin of Troy, Michigan; a son, William A. Brundage, at home; one sister, Mrs. Elizabeth Ballard of Wilmington, Delaware, and two grandchildren. One brother preceded him in death.

* * * *

BENJAMIN I. GOLDEN, M. D.

Dr. Benjamin I. Golden, founder of Memorial General Hospital and the Golden Clinic in Elkins, died there on August 2. He was 80. Doctor Golden served as Medical Director of the hospital and clinic from 1946 until he retired in 1971. He had been President of the hospital Board of Directors from 1952 until 1961.

From 1929 to 1946 he was Chief Surgeon and Medical Director of Davis Memorial Hospital and from 1946 to 1962 he was Chief Surgeon of Memorial General Hospital.

Doctor Golden received an A. B. degree from Tufts University and his M. D. degree in 1921 from Temple University. Doctor Golden had worked for 45 years for the establishment of Memorial General Hospital at its current location, a $7 million facility which was dedicated in 1967.

A community leader in Elkins for a half century, Doctor Golden was a member of the Tygart's Valley Medical Society, the West Virginia State Medical Association, the American Medical Association and the Radiological Society of North America. He was a Fellow of the American College of Surgeons, a Diplomate of the American Board of Surgery and a Diplomate and Fellow in the International College of Surgeons. He was a member and honorary member of the American Fracture Association and a Life Member of the American Hospital Association.

Doctor Golden is survived by one daughter, Mrs. Sara Lane Shriver of Pittsburgh; one sister, Mrs. Helen Paulson of Baltimore, and three grandsons.

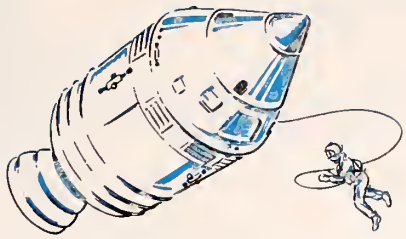
EVELYN A. MEADOWS, M.D.

Dr. Evelyn A. Meadows, a Hinton native who formerly was on the Weston State Hospital medical staff, died at her home in Weston July 15. She was 61.

Doctor Meadows was a graduate of West Virginia University and the Medical College of Virginia in Richmond. She interned at Peoples Hospital in Akron, Ohio and served residencies in Wallum Lake, Rhode Island; Hamburg, Pennsylvania, and Youngstown, Ohio.

A First Lieutenant while in 1943-45 military service, Doctor Meadows was a former member of the Central West Virginia Medical Society and the West Virginia State Medical Association, and a member of the American Medical Association.

She is survived by her mother, Mrs. Mary Alice Matteson Meadows, of Hinton, and a brother, James E. Meadows, also of Hinton.



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County Societies

TYGART'S VALLEY

The Tygart's Valley Medical Society held its annual meeting in June at the Tygart Lake Lodge in Grafton. The opening address was given by Dr. Worthy W. McKinney, then President of the State Medical Association.

The speaker for the scientific session was Dr. Paul E. Nora, Chairman of the Department of Surgery at Columbus-Cuneo Medical Center in Chicago; and Assistant Professor of Surgery at Northwestern University, Chicago. His topic was "Contemporary Biliary Surgery."

Approximately 65 persons attended the evening banquet session. The guest speaker was Dr. Richard E. Shearer, President of Alderson-Broaddus College, whose subject was "Myths About the Private Sector."

Winners of a golf tournament held during the morning at the Tygart Lake Country Club were Dr. Frank Mallamo of Fairmont, with the low gross score, and Dr. Dale Simmons of Clarksburg, runner up. Prizes were awarded to these winners, and also to Dr. Robert Chamberlain of Buckhannon for being close to the pin on the Number 3 hole.

Dr. Y. C. Fan was unanimously elected to membership in the business session which concluded the Annual Meeting.—A. Kyle Bush, M. D., Secretary.

Dr. Robert H. Moser Named Chief Editor of JAMA

The Board of Trustees has appointed Robert H. Moser, M. D., the Chief Editor of the *Journal of the American Medical Association* effective October 1. At the same time Doctor Moser will become Director of the Division of Scientific Publications, which has editorial responsibility for *JAMA* and the AMA's 10 specialty journals.

Hugh H. Hussey, M.D., who has held both positions since 1970, will remain a fulltime member of the staff as Editor Emeritus. He also will assume responsibilities for coordinating publication of the specialty journals.

A graduate of the Georgetown University School of Medicine, Doctor Moser, 50, currently practices internal medicine with the Maui Medical Group, Wailuku, Hawaii. Certified by the Board of Internal Medicine, Doctor Moser followed a career of medical officer in the U.S. Army, rising to the position of Chief of Medicine at Walter Reed General Hospital, Washington, D.C. He had an appointment to the clinical faculty at Georgetown, where he was active in teaching, research and the authorship of a number of original articles. Currently he is Clinical Professor of Medicine at the University of Hawaii and the University of Washington Colleges of Medicine.

Book Reviews

HANDBOOK OF PEDIATRICS—By Henry K Silver, C. Henry Kempe and Henry B. Bruyn. Lange Medical Publications. Los Altos, California. 10th Edition. Pp. 693. 1973. Price $6.50.

This 10th edition of what must be a very popular book fills the American requirements for a "Handbook" very completely. It fits into a coat pocket, scarcely overbalancing the stethoscope on the opposite side. The type, though small, is sharp, so that these in the bi-focal and tri-focal years can still read it. Most important, of course, it is packed with information, literally from cover to cover, arranged in a very clear and orderly fashion, so that the reader can review a subject in very few minutes, or pick out the desired bit of information at a glance. The authors admit that they have been guilty of dogmatism and over-simplification, but this is part of the price of a most convenient primary resource in pediatrics.

The first chapter covers the pediatric history and physical examination very thoroughly, with reminders for even the most experienced. The second, somewhat surprisingly, deals with pediatric management during illness. Some of it applies to ambulatory care, but it is principally concerned with hospital practice. Growth and development is then outlined, with a discussion of personality development that is particularly lucid. Nutrition and infant feeding are adequately covered, with much information here, as elsewhere in the book, in tabular form.

Anyone who is not dealing with fluid and electrolyte disorders every day will find great help in the chapter on this subject by Dr. Robert Winters. He has very clearly outlined their recognition and management, so that one's greatest uncertainty becomes staying in a vein. Even the excellent chapter on pediatric procedures, at the end of the book, does not make this a sure thing.

The uses of anti-infective chemotherapeutic agents and antibiotic drugs, immunization procedures, vaccines, antisera, skin tests and blood products are outlined very succinctly, with indications, contra-indications, incompatibilities and methods of administration. However, Doctor Kempe's positive opinions on the pros and cons of antibiotic prophylaxis were missed.

The two chapters on the Newborn: Assessment and General Care, and Diseases and Disorders, cover the field very adequately. This section was revised by Dr. Frank H. Morriss, Jr.

The physician who wishes to improve his handling of children with emotional problems will find Dr. Ruth Kempe's brief but lucid discussion more helpful than many books on the subject.

Diseases of organ systems and of specific or related etiologies are well covered, mostly in outline

or tabular form. It is interesting to note that steroid therapy for both infectious hepatitis and infectious mononucleosis is described. This must represent the influence of Doctor Bruyn, whose patients are college students.

Almost everyone who takes care of children can profit from reading the chapters on allergy and collagen diseases. They are excellent reviews of what can be very puzzling conditions. In the latter there was one important omission: the mention of abdominal pain in the acute, often pre-arthritic, stage of rheumatoid arthritis. This symptom can be outstanding, and is described by most authors.

A good section on pediatric emergencies is distinguished by some interesting and useful diagrams of the management of coma, convulsions, and dyspnoea.

The section on poisoning would have been more impressive if the authors had decided whether or not to lavage the stomach of a child who has ingested kerosene. They did admit that there is no such thing as "careful lavage" of a child's stomach.

An appendix with drug dosages, procedures in pediatrics, laboratory tests and values, and a diagnostic index of symptoms and signs completes the book. This is likely to be its most used section.

With this book for companion and primary support, one can practice very good pediatrics. In the interest of brevity, the authors have been quite dogmatic, and sometimes sacrificed "Why" for "What," "When," and "How," but they were writing for those who know some pediatrics, and need to know more in a hurry.—William J. Ball, M. D., Aurora, Illinois.

* * * *

PRINCIPLES OF CLINICAL ELECTROCARDIOGRAPHY (Goldman). Lange Medical Publications, Los Altos, California. 1973. Price $8.00.

This 400-page 8th edition was published in June 1973 and presents the basic concepts of electrocardiography and their clinical application; but it also gives the reader an insight into several new areas in this rapidly expanding medical field. The author states the ECG must always be interpreted in connection with clinical findings and, in general, the person best qualified to interpret the ECG is the physician who is caring for the patient.

The book is profusely illustrated and explanation of the cuts is adequate and clearly defined. Although the author states an exhaustive detailed treatment of the subject matter is not possible in this type of book, the average interpreter will find the book sufficiently informative.

The book is highly recommended to physicians who do their own electrocardiography, and also will be a satisfactory source for basic information and reference.

The price is right: $8.00.

(Continued on page xxii)

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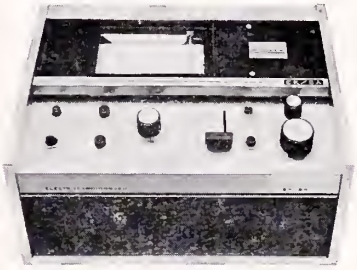

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AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS SYMPOSIUM ON MYELOMENINGOCELE—C. V. Mosby Company, St. Louis. 1972.

This book originated in a course on Myelomeningocele, given in 1970 at Hartford and Newington, Connecticut, under the auspices of the Academy of Orthopaedic Surgeons. Members of the Myelomeningocele Team of the Newington Children's Hospital served as both authors and editors, with other contributors from as far away as California, and Sheffield, England.

It is "an overview of the philosophy, treatment methods, technique, and general understanding of the problems encountered in the management of patients with myelomeningocele and related disorders." This is now the largest and most important deformity syndrome in modern pediatrics, with an incidence of 0.1 to 4.13 per 1,000 live births, in different ethnic groups, which is surprising.

The pathology of the various types of this syndrome, with that of their complications, is very clearly presented, with clear diagrams and photographs of x-rays and of findings at operation and postmortem. It is reassuring to learn that, while no definite etiology has been found, all evidence points to a combination of multiple genetic and environmental influences. Thus, responsibility for this disaster cannot honestly be assigned to or assumed by any person or family.

The management of this spinal dysraphism syndrome, from the moment of birth through the rest of their lives, is discussed by men who have followed hundreds of cases. The problem of the child who is so severely affected that no treatment may be the most humane, is considered very carefully, with the establishment of some guidelines. This condition being a tremendous catastrophe to the families involved, the approach to them and methods of assisting them is discussed from several points of view. As Americans proverbially have a club for it, a parents' organization has been established.

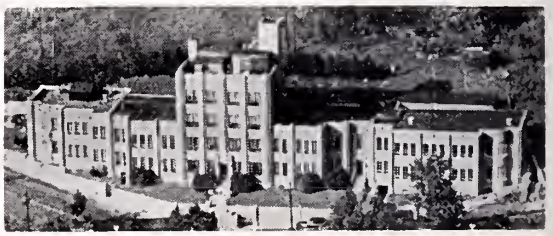
Hydrocephalus is the usual cause of death in the first two years. It can be managed by shunting, early, with little apparent loss of intelligence in a high percentage of cases. However, it is an ongoing problem, the shunt requiring multiple revisions as the child grows, and being subject to mechanical and infectious complications.

After two years, deformities and obstructions of the urinary tract, due to paralysis, become the principal cause of death. The surgical formation of an ileal conduit, or transplanting the ureters to an isolated segment of ileum, emptying through a stoma in the abdominal wall, seems to be the most satisfactory approach to the urinary problems of these children.

Long-term follow up shows that victims of the spinal dysraphism syndrome can attain intelligence within the normal range, advanced education, financial independence, and social success, even to the point of marriage and children.

With this hopeful finding, the principal message of this book is that the management of meningomyelocele and its complications is a job for an interdisciplinary medical and para-medical team, including the parents. No one should attempt it alone. Hospitals with an active obstetrical service should have this book in their libraries. Sooner or later someone will need its expert guidance. A companion volume, describing day-to-day care from the standpoint of the nurse and family, would be very welcome to homes and hospitals.—William J. Ball, M. D., Aurora, Illinois.

PHYSICIAN needed to provide examinations and treatment in Spinal Cord Injury Service of hospital. U. S. licensure required. 875-bed GM&S Hospital affiliated with Medical School. Excellent retirement and leave benefits. Nondiscrimination in employment. Contact Chief, Spinal Cord Injury Service, VA Hospital, Richmond, Virginia 23249. Telephone (703) 233-9631, Ext. 272.



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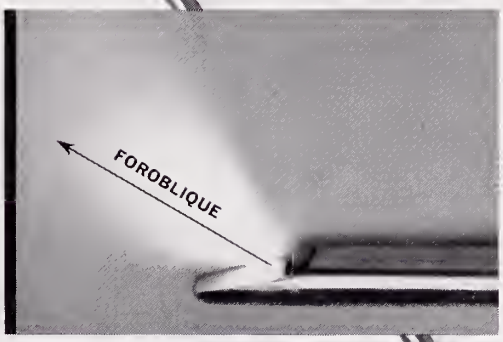

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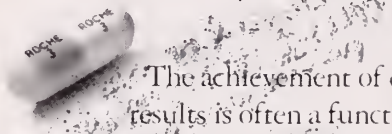

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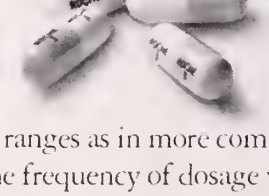

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Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-800-F (10/71)
For complete details, including dosage, please see full prescribing information.

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When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e g , excitement, stimulation and hyperactivity, have also been reported in rare instances

Dosage: Individualize for maximum beneficial effect *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients *Elderly or debilitated patients:* 15 mg initially until response is determined

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association

"Too many doctors are indiff ent to the economic consequence their decisions." So stated a recen issue of *Medical News Report* (De cember 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasir game, M.D.

Doctor, are you indifferent . . . ?

In discussing an anticipated crease in Blue Shield rates, Dr. Bl ingame's newsletter had this to sa

"In general, it can be said, M s have given the impression they are not particularly concerned with th increase in cost of health care to t patients . . .

"True, an MD's training is pri marily scientific, but in the real wo of practice, all of his scientific dec sions have a price tag, or an econo impact. The economics of health c beckon the practitioner's attentior Concern for economics of medicin

When the pharmacist recom mends that a drug product other t the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inte ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know tha the change is being contemplated, and to be in a position to consent o demur. Without that opportunity, t unilateral decision of the pharmac made in the absence of clinical kn edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth g in the pro-substitution argument t offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowlec about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degr puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than

Advertisement

ld be an obligation of medical tice...

"Medical societies ought to con- continuing campaigns to point he substantial savings that could alized thru deductible insurance protection for catastrophic ill- . At the very least, they should, in atients' interest, question the cs of any insurance organization raises health care costs by forc- olicyholders to buy insurance may not need or want and prob- won't ever use.

"Too many doctors are indiffer- o the economic consequences of decisions. Too many, for ex- le, habitually hospitalize patients he convenience of the MD. It's sense to deny such habits exist...

"Doctors, thru their medical so- es, have unhesitatingly appealed eir patients for support in the t against government interference the private practice of medicine. the public in the past has re- nded. It's time the American Med- Association and state and local dical societies paid off the debt by isive action to hold down the cost edical care."

t of Drugs

Insurance rates and hospital rges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

0 drugs that he selects to treat the jority of conditions encountered in practice. Moreover, the physi- n's choice of a specific brand is ed on his knowledge of the pa- t's medical history and current dition, and his experiences with particular manufacturer's duct.

Some substitution proponents e argued that the dispensing of a scription is a simple two-party nsaction between the pharmacist l the patient, and that a substitut- pharmacist may avoid even a hnical breach of contract by simply ifying the patient that he is making substitution. I would judge that courts would be sympathetic ard a pharmacist who substituted hout physician approval and who dertook a legal defense that seeks make the patient responsible for pharmacist's actions.

duced Prescription Prices?

Substitution advocates are ggesting to the consumer, and par- ularly the consumer activist, that duced prescription prices could low legalization of substitution. have seen absolutely no evidence justify this claim. To the contrary, perience in Alberta, Canada, where bstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

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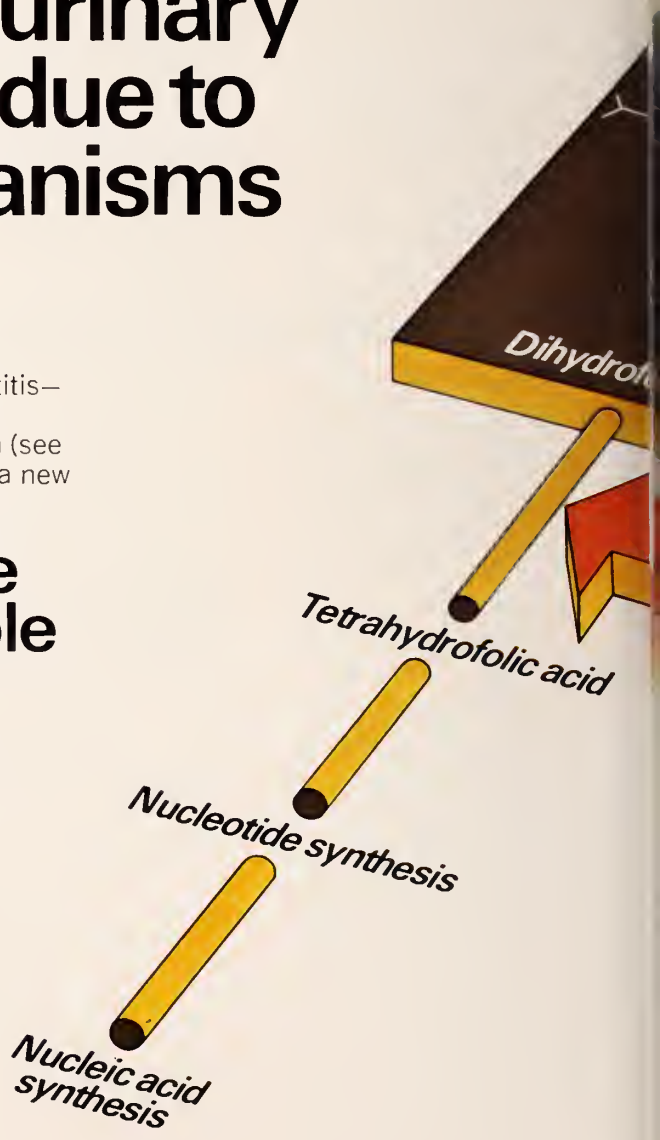
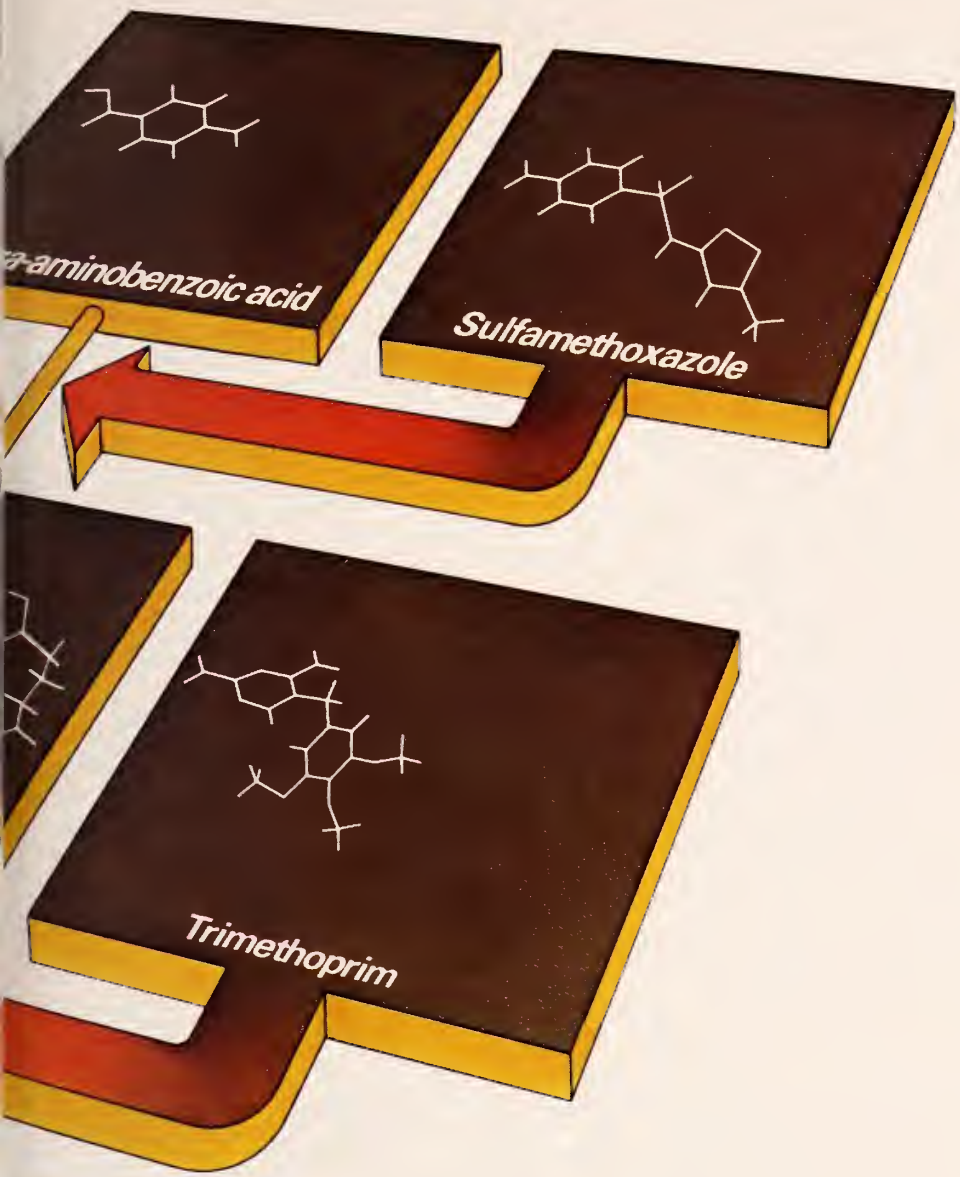
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





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for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

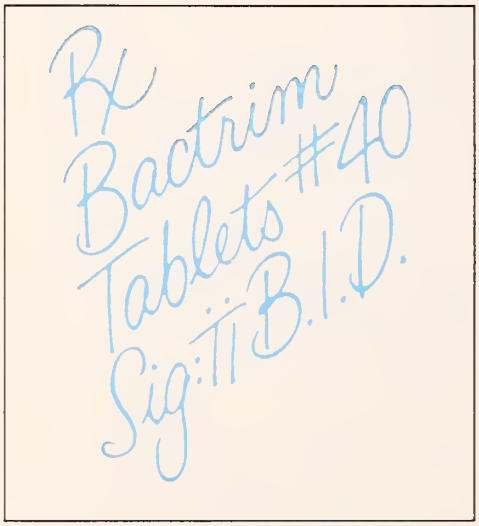
Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
†4 patients not available for evaluation at day 10.



new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

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Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

lete Product Information:

iption: Bactrim is a synthetic antibacterial combination prod- vailable in scored light-green tablets, each containing 80 mg thoprim and 400 mg sulfamethoxazole.

:thoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. white to light-yellow, odorless, bitter compound with a molec- veight of 290.3.

nethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is nost white in color, odorless, tasteless compound with a mo- ar weight of 253.28.

ns: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis ydrofolic acid by competing with *para*-aminobenzoic acid. thoprim blocks the production of tetrahydrofolic acid from di- folic acid by binding to and reversibly inhibiting the required ne, dihydrofolate reductase. Thus, Bactrim blocks two con- ive steps in the biosynthesis of nucleic acids and proteins ntial to many bacteria.

ro studies have shown that bacterial resistance develops more y with Bactrim than with trimethoprim or sulfamethoxazole .

ro serial dilution tests have shown that the spectrum of anti- rial activity of Bactrim includes the common urinary tract ogens with the exception of *Pseudomonas aeruginosa*. The fol- g organisms are usually susceptible: *Escherichia coli, Kleb- Enterobacter, Proteus mirabilis* and indole-positive proteus es.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

teria	Trimeth-oprim alone	Sulfameth-oxazole alone	TMP/SMX (1:20) TMP	SMX
nerichia	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
eus spp. ole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
eus abilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
osiella-erobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

an Pharmacology: Bactrim is rapidly absorbed following oral inistration. The blood levels of trimethoprim and sulfamethoxa- are similar to those achieved when each component is given e. Peak blood levels for the individual components occur one ur hours after oral administration. The half-lives of sulfameth- ole and trimethoprim, 10 and 16 hours respectively, are rela- / the same regardless of whether these compounds are admin- ed as individual components or as Bactrim. Detectable unts of trimethoprim and sulfamethoxazole are present in the d 24 hours after drug administration. Free sulfamethoxazole trimethoprim blood levels are proportionately dose-dependent. epeated administration, the steady-state ratio of trimethoprim lfamethoxazole levels in the blood is about 1:20.

amethoxazole exists in the blood as free, conjugated and pro- bound forms; trimethoprim is present as free, protein-bound metabolized forms. The free forms are considered to be the apeutically active forms. Approximately 44 percent of trimeth- m and 70 percent of sulfamethoxazole are protein-bound in the d. The presence of 10 mg percent sulfamethoxazole in plasma eases the protein binding of trimethoprim to an insignificant ee; trimethoprim does not influence the protein binding of amethoxazole.

etion of Bactrim is chiefly by the kidneys through both glomer- filtration and tubular secretion. Urine concentrations of both amethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together n Bactrim, neither sulfamethoxazole nor trimethoprim affects urinary excretion pattern of the other.

cations: Chronic urinary tract infections (primarily pyelonephri- pyelitis and cystitis) due to susceptible organisms (usually coli, *Klebsiella-Enterobacter, Proteus mirabilis,* and, less fre- ntly indole-positive proteus species).

ortant note: Currently, the increasing frequency of resistant organ- s is a limitation of the usefulness of all antibacterial agents, espe- y in the treatment of chronic and recurrent urinary tract infections.

traindications: Hypersensitivity to trimethoprim or sulfonamides. gnancy and during the nursing period (see Reproduction dies).

nings: Deaths associated with the administration of sulfonamides e been reported from hypersensitivity reactions, agranulocyto- aplastic anemia and other blood dyscrasias. Experience with nethoprim alone is much more limited, but it has been reported nterfere with hematopoiesis in occasional patients. In elderly ients concurrently receiving certain diuretics, primarily thia- es, an increased incidence of thrombopenia with purpura has n reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley N.J. 07110

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Servic

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbi and Mortality Weekly Report*, the Ad ory Committee on Immunization P tices of the United States Public He Service presented recommendations the use of combination live virus vacci The committee stated that:

- "Data indicate that antibody respo to each component of these combinat vaccines is comparable with antibody sponse to the individual vaccines gi separately.
- "There is no evidence that verse reactions to the combi products occur more f quently or are more sev than known reactions to individual vaccines (see p tinent ACIP recommen tions).
- "The obvious convenie of giving already selec antigens in combined f should encourage conside tion of using these produ when appropriate."

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	**Vaccine(s)**
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

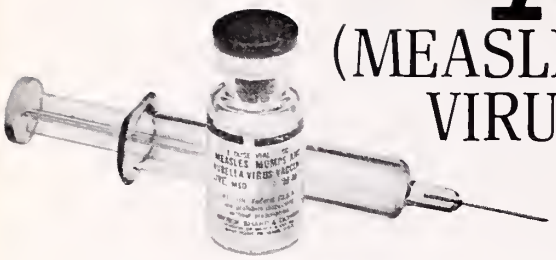
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD

MERCK SHARP & DOHME

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs

Butisol SODIUM
(SODIUM BUTABARBITAL)

Contraindications: Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

Synthroid®
(sodium levothyroxine)

the smooth road to thyroid replacement therapy.

Synthroid is T4. It provides your patients with what is needed for complete thyroid replacement therapy.

Free Tab-Minder sample packages available from Flint Professional Services Department.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's Disease (chronic adrenocortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to pa[illegible] with cardiovascular disease; developme[illegible] chest pains or other aggravations of card[illegible]cular disease requires a reduction in dosa[illegible]

Contraindications: Thyrotoxicosis, acute m[illegible]dial infarction. **Side effects:** The effects of [illegible]THROID (sodium levothyroxine) therapy are [illegible] in being manifested. Side effects, when th[illegible] occur, are secondary to increased rates of [illegible] metabolism; sweating, heart palpitations [illegible] or without pain, leg cramps, and weight [illegible]ss. Diarrhea, vomiting, and nervousness have [illegible] been observed. Myxedematous patients [illegible] heart disease have died from abrupt incr[illegible]ses in dosage of thyroid drugs. Careful obser[illegible]ion of the patient during the beginning of an[illegible]roid therapy will alert the physician to an[illegible] toward effects.

It has been shown that *Synthroid* (T_4) converts to T_3 at the cellular level to supply metabolic needs.[1, 2]

1 *Synthroid* is T_4.

2 Because T_4 converts to T_3 at the cellular level, it provides full thyroid replacement at maintenance doses.[1, 2]

3 T_4 hormone content is controlled by chemical assay.

4 *Synthroid* is assayed chemically; no biologic test is necessary to measure potency.

5 *Synthroid* provides predictable results when used with current thyroid function tests.

6 *Synthroid* is the most prescribed brand name of thyroid in the U. S. and Canada.

7 Sodium levothyroxine in *Synthroid* tablets is chemically pure. It does not contain any animal gland parts.

8 When stored properly, *Synthroid* has a longer shelf life than desiccated thyroids.

9 On a daily basis, *Synthroid* is cost competitive with other thyroid products.

The smooth road to thyroid replacement therapy.

Synthroid®
(sodium levothyroxine)

most cases with side effects, a reduction of ge followed by a more gradual adjustment rd will result in a more accurate indication e patient's dosage requirements without the arance of side effects.

ge and Administration: The activity of l mg. SYNTHROID (sodium levothyroxine) ET is equivalent to approximately one grain id, U.S.P. Administer SYNTHROID tablets single daily dose. In hypothyroidism with- myxedema, the usual initial adult dose is ng. daily, and may be increased by 0.1 mg. 30 days until proper metabolic balance is ned. Clinical evaluation should be made thly and PBI measurements about every 90 . Final maintenance dosage will usually e from 0.2-0.4 mg. daily. In adult myxedema, ing dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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Deerfield, Illinois 60015

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A lot of people don't buy U.S. Savings Bonds because they think it takes them 10 years to mature. Take another look. The old green Bond ain't what it used to be. Now Bonds mature in less than 6 years.

That's one reason Bonds are so popular nowadays. They're simple to buy, and one of the surest ways to build a nest egg for something (or someone) special.

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Take stock in America.

Bonds mature in less than six years.

Now E Bonds pay 5½% interest when held to maturity of 5 years, 10 months (4% the first year). Bonds are replaced if lost, stolen, or destroyed. When needed they can be cashed at your bank. Interest is not subject to state or local income taxes, and federal tax may be deferred until redemption.

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Kids' Stuff

Triaminic® Syrup...the orange medicine from Dorsey

Dorsey Laboratories / Division of Sandoz-Wander, Inc. / Lincoln, Nebraska 68501

Healing nicely, but it still HURTS

EMPIRIN COMPOUND c̄ CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

HERE

Burns

When parenteral analgesia is no longer required, Empirin Compound with Codeine usually provides the relief needed.

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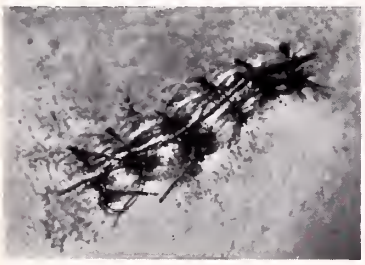

Empirin Compound with Codeine is effective for visceral as well as soft tissue pain—provides an antitussive bonus in addition to its prompt, predictable analgesia.

prescribing convenience: up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1). *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

Wellcome

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when manhood ebbs...
due to testicular deficiency

Halotestin® 5 mg tablets
fluoxymesterone, Upjohn **oral hormone replacement**

*"When impotence is the principal complaint of a patient, it is usually the result of an emotional disturbance, in which case androgen therapy is valueless and at times may add to the psychic trauma."**

Halotestin® Tablets—2, 5 and 10 mg
(fluoxymesterone Tablets, U.S.P., Upjohn)

Indications in the male: Primary indication in the male is replacement therapy. Prevents the development of atrophic changes in the accessory male sex organs following castration: **1.** Primary eunuchoidism and eunuchism. **2.** Male climacteric symptoms when these are secondary to androgen deficiency. **3.** Those symptoms of panhypopituitarism related to hypogonadism. **4.** Impotence due to androgen deficiency. **5.** Delayed puberty, provided it has been definitely established as such, and it is not just a familial trait.

In the female: 1. Prevention of postpartum breast manifestations of pain and engorgement. **2.** Palliation of androgen-responsive advanced, inoperable female breast cancer in women who are more than 1, but less than 5 years post-menopausal or who have been proven to have a hormone-dependent tumor, as shown by previous beneficial response to castration.

Contraindications: Carcinoma of the male breast. Carcinoma, known or suspected, of the prostate. Cardiac, hepatic or renal decompensation. Hypercalcemia. Liver function impairment. Prepubertal males. Pregnancy.

Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

How Supplied:
2 mg—bottles of 100 scored tablets.
5 mg—bottles of 50 scored tablets.
10 mg—bottles of 50 scored tablets.

For additional product information, see your Upjohn representative or consult the package circular. J-3262-4 MED B-6-S (MAH)

*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 13. Beesan, P. B. and McDermatt, W. eds. Philadelphia, W. B. Saunders Co., 1971, p. 1816.

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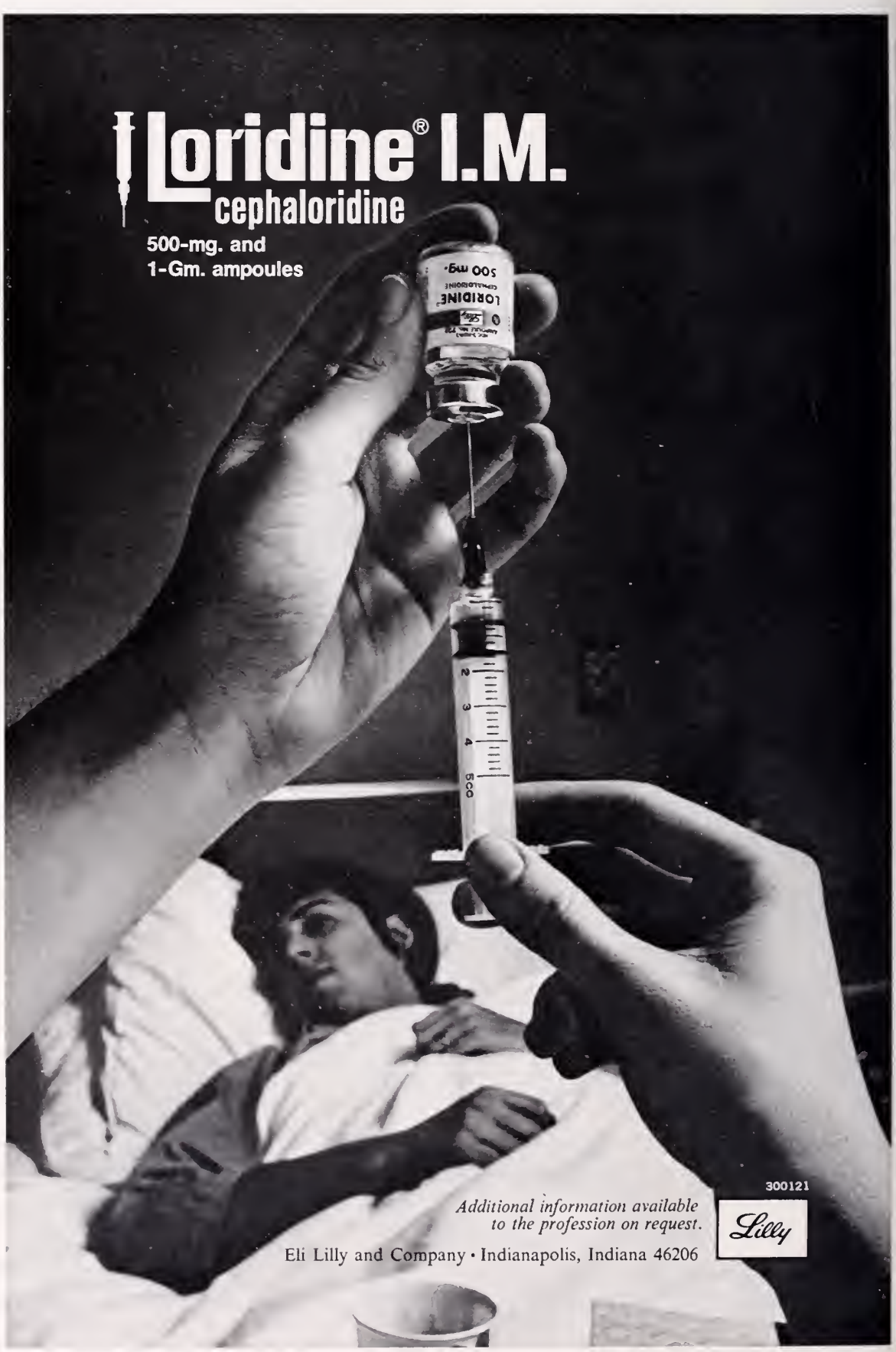
Upjohn

The Upjohn Company, Kalamazoo, Mich. 49001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The West Virginia Medical Journal

Vol. 69, No. 10 October, 1973

Presidential Address*

Worthy W. McKinney, M.D.

Some of you may remember the final word of my remarks following my installation last August. That important word was, *"Help."*

I have received that help from *many* during the past year and I especially thank my companion who has shared many of this past year's experiences; my wife, Bertha. I would like to introduce her to you.

I thank the staff of the West Virginia State Medical Association who keeps your organization running smoothly in spite of the interference of the officers of your Association. They are Bill Lively, our Executive Secretary, Custer Holliday, Charles Lewis, Mary Hamilton and Sue Shanklin.

I thank the Council and the Executive Committee for their advice and guidance.

I thank the Chairmen and members of the Committees of the Association, with particular thanks to President Elect Tom McCoy and the Program Committee for their efforts connected with this meeting.

Finally, I thank the officers and members of the Auxiliary who have had an active and productive year. Bertha and I have enjoyed the year. It has been a good year for us.

As President, I have attended the AMA meetings, four other national meetings, the state meetings of the six surrounding states and the District of Columbia and meetings of all of the component societies that asked me to come. I am a richer person, having had the opportunity to visit many cities and meet new people during the past year.

During the past year, I have told the story of my father who was a family doctor in Oklahoma and how his methods of practicing medicine changed during the 50 plus years between 1912 and 1965. I stressed the fact that he did not like his patients less or the practice of medicine less

The Author

- **Worthy W. McKinney, M.D., Immediate Past President, West Virginia State Medical Association.**

Worthy W. McKinney, M. D.

*Presented at the second and final session of the House of Delegates, 106th Annual Meeting of the West Virginia State Medical Association, The Greenbrier, White Sulphur Springs, W. Va., Saturday, August 25, 1973.

because he and his methods changed with the times.

I have also stated that many of today's physicians do not, and should not be expected to, neglect their families and personal lives to cater to the "24-hour demand" of patient care. Medical care *should* be available to all who need it. But no individual physician should be expected to be available where and at the convenience of each person who feels he needs medical care.

Change Is the Name of the Game

The practice of medicine has changed and should continue to change, *but not* with loss of liberty to physicians.

Your leaders in the West Virginia State Medical Association and the AMA have stressed the importance of participation in political affairs. I repeat their plea! Through the efforts of you and your money, WESPAC and AMPAC have had an influence, however insignificant, on several matters of importance to physicians. We must continue to support the PAC movement. We must continue to use our money and our voices to try to save the principles we believe in.

After seeing the activities of the staff of surrounding states, I am impressed with the productivity of our staff. With increased involvement and activities, with the continuing education certification, we may need more staff. With possible increased scholarships; pending institute and PSRO activities, and with increased costs and Association expenses, we will probably need a substantial dues increase soon.

Physicians with temporary licenses continue to be a problem in West Virginia. The Medical Licensing Board has taken a more realistic approach to the problem in the past year. We hope that soon all physicians practicing in West Virginia will have demonstrated competence in medicine by having passed qualifying examinations. And we hope that all newly licensed physicians will have passed these exams *before* they are licensed.

Some Problems Continue from Year to Year

Our problems with third-party payors—private, state and federal—are continuing. Many, many years ago, when the first physician filled out the first health and accident insurance form, we started that long road to our present position.

In the private health insurance sector, including Blue Shield, the physician is doing the paper work for the third-party payors. When the State became involved in Compensation, Welfare programs and Vocational Rehabilitation, the physician was involved further — still doing their paper work. And when the Federal government became involved with disability determination, Social Security evaluation, CHAMPUS, Medicare, etc., the physician was still doing the paper work and more of it!

And all this extra work for less than usual and customary fees—fees that some clerk who has no medical training decides are appropriate! These fees are not even uniform throughout the State, much less over the United States.

The multiplicity of forms and the absurdity of information requested by the third parties never cease to amaze the physician and his secretarial staff. The continuing effort to develop a standard form and eliminate requests for useless information may succeed in time.

Again, I must point out that individual insurance policies are contracts between the insured person, the patient and the insurance company. Benefits from this contract are to help the patient pay his medical expenses. These contracts *are not* between the physician and the patient's insurance company to guarantee payment to the physician. The insurance company that profits from the contract should be responsible for completing the claim forms of its customers.

PSRO

And now we are about to embark on Professional Standards Review Organizations, another federal program forced upon the physician in the name of quality medical care. I do not feel that the health care planners in Congress and HEW expect anything out of PSRO except "cost control." And once more, the physicians, who are the only ones qualified to determine quality of care, and necessity of care, are expected to develop and make the program work for this government agency. We have until 1976! During that time one or more of our provisional PSRO's may develop guidelines or criteria that HEW will consider the model vehicle for proper cost control. Then, that model can be implemented on a nationwide scale. If the chiropractors would come up with a model plan for health care with minimal cost to the government, I believe that plan would be the one chosen.

Talk About the Problems

One of the reasons that our problems persist is that many physicians are not confronted with them. How can a physician know of problems with third-party payors when he does not deal with them? You have to treat the Compensation patient, the Vocational Rehabilitation patient, the Welfare patient, and the Medicare patient; fill out their forms — all of them — try to understand a reduced fee for a service arranged for

by one of these agencies' representatives or social workers, and then try to explain to the patient why the bill is not paid or an answer to an inquiry is not received.

How many times have some of you tried to explain to an elderly patient, or his family, the financial workings of Medicare? As an ophthalmologist, who deals or has dealt with almost all of the third-party payors, I have faced many of the problems and I must confess I have solved few of them. But I do feel better when I talk about it!

Just the other day a physician told me that we should cooperate with the PSRO agency because he thought they might try to set our fees. In the same conversation, he stated that he accepted "assignment" under Medicare. Ladies and gentlemen, when the first physician accepted the first assignment under Medicare, we permitted the federal government to set the value of our services.

Now the allowable values are set and frozen and these values are not consistent for physicians in the same locality in the same state, much less throughout the nation.

We shall try to cooperate with PSRO in determining norms, quality of care and necessity for care — since we all feel that only physicians have the professional qualifications to determine them. But if our experiences with Medicare and other federal programs can be used as a guide, our cooperation may not help us in the long run. If I sound pessimistic, I am.

Now A Cheerful Note

Every President of the West Virginia State Medical Association has aims that he would like to accomplish during "his year." Few, if any, come to pass.

The House of Delegates, in past actions, has supported the establishment of a Department of Family Practice at the West Virginia University School of Medicine and we are happy to learn that a Chairman for this Department, Dr. John W. Traubert of Wellsburg, has been appointed. We encourage the rapid development of the program of the Department at the University.

The present program for financial support of residencies in other hospitals, particularly the new family practice residencies, is significant and should be endorsed wholeheartedly.

Emergency medical services have changed for the better in the past year. Cooperative efforts of the Department of Health, the Regional Medical Program, the Southern West Virginia Regional Health Council, individual hospitals and the West Virginia State Medical Association have resulted in several well equipped, functioning, emergency medical services — a welcomed improvement that should be expanded throughout the State.

The Medical Examiner System in West Virginia may soon become a reality. After enabling legislation and now financial support, West Virginia may soon see an active System. We encourage its rapid development.

Last August, the House of Delegates authorized the Council to proceed with the development of a corporation separate from the State Medical Association. This corporation would handle many activities which the State Medical Association cannot practically or legally coordinate.

After much work and many revisions, a charter application for this West Virginia Medical Institute is ready for filing with the Secretary of State. The corporation can be the vehicle we need for our continuing education program and contract with third parties. Finally, it has been modified to conform to the membership requirements of P.L. 92-603 so that, if and when the time is right, this Institute can apply to HEW to become the provisional PSRO for West Virginia.

The name was changed to "Institute" to try to avoid the confusion associated with "Foundations" which may be health-care delivery corporations—a type of HMO.

Resolution No. 7 introduced by the Council asks that the House of Delegates:

(1) Support a State-wide PSRO area designation for West Virginia.

(2) Reaffirm support of the West Virginia Medical Institute, Inc., concept.

I must call to your attention that the Institute will not be synonymous with the State Medical Association, although membership provisions should give us a realistic working relationship with it.

I urge the delegates to support Resolution No. 7.

Your Council and your chosen capable leaders in the State Medical Association will continue to press for your best interests in West Virginia in all matters at all times.

As I have stressed before, you must keep your Councilors informed so they may act as your agents. And you must demand that your Councilors report to your component societies matters of importance to you.

Thank you for the honor of serving as your President this past year.

Hemorrhagic Disease Of The Newborn And Vitamin K Prophylaxis

Richard Gnegy, M. D.

THE entity of Hemorrhagic Disease of the Newborn can be defined as a spontaneous bleeding disorder which occurs between the second and fifth days of life, and which is due to an exaggeration of multiple coagulation deficiencies which are normally present in the newborn. Since the coagulation factors involved are all Vitamin K dependent, the prophylactic administration of Vitamin K has been advocated in attempts to prevent the occurrence of this disorder.

Townsend, in 1894, described Hemorrhagic Disease of the Newborn as a bleeding diathesis which had no definable etiology, such as infection, anoxia, and the like. Various researchers subsequently documented a disturbed clotting mechanism in the newborn; but not until 1937 was it demonstrated that newborns had low prothrombin levels. Furthermore, infants with a hemorrhagic tendency displayed particularly diminished levels of prothrombin. Following this, the use of Vitamin K in the treatment and prophylaxis of this disorder quickly became established. Since that time, the demonstration of other coagulation defects besides hypoprothrombinemia and conflicting reports in regard to the effect of Vitamin K on these factors, as well as reports of toxicity of large doses of Vitamin K, have provided the basis for unlimited controversy concerning the routine prophylactic use of Vitamin K in the newborn.

At birth, the normal newborn has a prothrombin content of only 20-50 per cent of the adult value. Likewise, the levels of the other Vitamin K dependent clotting factors, VII (proconvertin), IX (plasma thromboplastin component), and X (Stuart-Prower), may also be lower than that observed in adults. On the other hand, the platelet count and levels of factors V, VIII, and fibrinogen are within the normal range. The prothrombin time, which measures the activity of factors V, VII, and X, as well as prothrombin (II), may be normal or prolonged at birth.

During the first few days of life, the prothrombin time undergoes a gradual but persistent prolongation in response to increasing deficiencies of factors II, VII, and X. The low point occurs at about the third or fourth day, and by the end of the first week, levels comparable to those seen at birth are observed. Hemorrhagic Disease of the Newborn is merely a bleeding disorder resulting from an exaggeration of these physiologically-occurring defects during the first week of life.

The Author

- **Richard Gnegy, M. D., Resident in Pediatrics, West Virginia University School of Medicine, Morgantown.**

The clinical picture of Hemorrhagic Disease of the Newborn involves the occurrence of overt bleeding starting between the second and fifth days of life from such sites as the cord stump and circumcision wounds. Melena, hematemesis and hematuria may reveal the existence of internal hemorrhage whereas intracranial bleeds may provide the most serious problem. The bleeding time and platelet count usually are within the normal range as may be the clotting time, but the prothrombin time is markedly prolonged. Either transfusions of fresh blood as a source of clotting factors as well as red cell replacement or injections of Vitamin K will effectively control this bleeding. Vitamin K administration lowers the prothrombin time by providing the essential vitamin for synthesis of these same factors by the liver. The newborn infant is especially prone to develop Vitamin K deficiency as he has not yet acquired normal intestinal flora that synthesizes the vitamin. This will occur within the first week. It is both the recognition that the normally deficient coagulation factors are Vitamin K dependent and the fact that Vitamin K is effective in the treatment of Hemorrhagic Disease of the Newborn which form the basis for the prophylactic administration of Vitamin K to all newborns.

Since the onset of prophylactic Vitamin K usage, numerous studies have been conducted to elucidate the effect of the vitamin on the newborn's coagulation status. The results reported, however, have been conflicting and confusing. Some investigators propose that Vitamin K administered prophylactically does not affect the normal decrease of the coagulation factors seen during the first days of life while others report a significant difference observed in the prothrombin times of infants given the drug compared with untreated newborns.

Fortunately, researchers are much more in agreement in evaluating the effect of Vitamin K prophylaxis in preventing clinically apparent hemorrhage in newborns. Numerous reports have documented the decreased incidence of significant bleeding in newborns receiving Vitamin K routinely compared to control groups. Likewise, two groups have reported a significant increase in the incidence of Hemorrhagic Disease of the Newborn in their respective nurseries after the discontinuance of prophylactic Vitamin K. Researchers also have documented a decreased incidence of post-circumcision bleeding in Vitamin K treated newborns.

Furthermore, the Committee on Nutrition of the American Academy of Pediatrics recommends that all newborns receive a prophylactic dose of Vitamin K at birth.

Vitamin K Controversy

In the face of these reports, there still exists a great deal of controversy concerning prophylactic Vitamin K, and hesitation on the part of practitioners to utilize the drug in this manner. This stems not only from those reports which fail to document any effect of Vitamin K on the coagulation studies, but also from reports of Vitamin K toxicity in newborns. Hemolytic anemia, hyperbilirubinemia and kernicterus have been reported in association with Vitamin K administration, particularly in the premature. A more critical evaluation of these reports, however, reveals that the dosage of Vitamin K administered exceeded recommended prophylactic levels, and that water-soluble Menadione (Vitamin K_3, Synkavite, and Hykinone) was the drug involved. There have been no reports of these toxic effects when naturally occurring Vitamin K_1 (Phylloquinone, Phytomadione, Aquamephyton) has been utilized in the recommended prophylactic doses of 0.5–0.1 mg. In fact, Vietti found no significant differences in the serum bilirubin, reticulocyte count, hematocrit, nor peripheral blood smear in newborns receiving five mg. Vitamin K_1 intramuscularly as compared with untreated controls. Therefore, by utilizing Vitamin K_1 preparations in the recommended dosages, these toxic effects do not present a hazard nor a deterrent to its prophylactic use.

Breast Fed Babies

The routine use of Vitamin K becomes even more important when considering breast fed babies. Hemorrhagic Disease of the Newborn is virtually nonexistent in newborns fed on cow's milk preparations. Even in the absence of overt bleeding, the most marked falls in prothrombin activity have been repeatedly noted to occur in breast fed infants. In a prospective study involving well newborns on various formulas, Keenan attempted to explain this phenomenon by determining prothrombin times at various intervals during the first two days of life. A significant difference in the prolongation of prothrombin times was observed in the breast fed babies, even with measured quantities of human milk equal to the amount of cow's milk ingested by the bottle fed newborns. He related this to the decreased Vitamin K activity of human milk compared with that of cow's milk (15 mcg/L versus 60 mcg/L). This relation of prothrombin times to dietary Vitamin K intake was further confirmed by the observation that newborns on a diet of only sterile water with no Vitamin K activity displayed an elongation of prothrombin time even more marked than that of breast fed infants.

Similarly, premature infants are more susceptible to develop Hemorrhagic Disease of the Newborn than are term infants. Coagulation studies reveal that the physiological drop in the clotting factors which occurs during the first two to three days of life is even more pronounced in prematures. This, added to the increased risk of hemorrhage from capillary fragility due to anoxia, makes this group particularly vulnerable to bleeding. Although prophylactic Vitamin K is to be urged in this group also, the results with prematures have not been as promising. Evidently, the added immaturity of the premature liver prevents the optimal synthesis of many of the coagulation factors even in the presence of sufficient Vitamin K.

At West Virginia University Medical Center, our policy includes administration of Vitamin K_1 at a dosage of one-half mg. intramuscularly to all newborns immediately upon being admitted to the nursery. Although some groups advocate Vitamin K administration to the mother prior to delivery, we believe that direct administration to the newborn is more reliable and effective, and at least as convenient for the nursing staff.

We have not been able to document any toxic nor untoward effects from the use of this particular preparation at this dosage.

In conclusion, it would appear that the prophylactic administration of Vitamin K_1 at the recommended levels provides a valuable adjunct in preventing neonatal hemorrhage. Although Hemorrhagic Disease of the Newborn is easily treated once recognized, prophylactic Vitamin K usage may prevent sequelae which would result from damage incurred before effective therapy could be instituted.

A list of references may be obtained by writing The Journal.

X-Ray Case of the Month

Unusual Filling Defect In The Small Bowel

Catalino B. Mendoza, Jr., M. D.; C. S. Krishna Murthy, M. D.; William C. Dressler, M. D.; Erlinda DeLaPena, M. D.; George W. Easley, M. D.; and Raymond C Bonnabeau, Jr., M. D.

THE following case report is that of a 63-year-old white male admitted on October 13, 1972, with the chief complaints of vomiting and slight epigastric pain for about three days prior to admission. The patient gave a history of vagotomy and gastrojejunostomy for duodenal ulcer disease about seven years previously and stated he had been in relatively good health until his present illness.

Physical examination revealed the patient to be fairly well developed, afebrile but dehydrated, with blood pressure 130/100, pulse 88 per minute, respirations 16 per minute. The heart had normal sinus rhythm, no murmurs; no rales in the lungs. The abdomen was soft, slightly distended, with slight tenderness at the epigastric region, active bowel sounds, no rebound tenderness. On rectal examination there were no tarry stools and the prostate gland was not enlarged.

Laboratory workup revealed white blood count 9,800, hemoglobin 10.8, hematocrit 34, neutrophils 81 per cent, lymphocytes 14 per cent, eosinophils 2 per cent, monocytes 2 per cent, platelet count normal. Serum electrolytes showed sodium 138, potassium 4.2, chloride 87, CO_2 36. Fasting blood sugar was 135 mg. per cent, urea nitrogen 7.

Electrocardiogram was interpreted as possibly indicative of old myocardial infarction.

X-rays were taken at the time of admission. Flat plate and upright view of the abdomen revealed signs of partial bowel obstruction. Barium enema showed no evidence of obstruction of the large bowel.

Treatment

The patient was treated with fluid and electrolyte replacement. A Cantor tube and nasogastric tube were inserted to decompress the gastrointestinal tract. Despite treatment, the patient did not improve. Upper GI series and small bowel series were performed on October 30, 1972, showing gastrojejunostomy with no evidence of obstruction or ulceration at the site of anastomosis. Subsequent films of the small bowel revealed considerable dilatation of the proximal portion of the jejunum. The mucosal folds were stretched and there were retained secretions producing a mottled appearance. This film also revealed a large radiolucent filling defect in the midportion of the jejunum and

The Authors

- **Catalino B. Mendoza, Jr., M. D.; C. S. Krishna Murthy, M. D.; William C. Dressler, M. D.; Erlinda DeLaPena, M. D.; George W. Easley, M. D.; and Raymond C. Bonnabeau, Jr., M. D., all from the Departments of Surgery, West Virginia University School of Medicine, Morgantown; and Veterans Administration Hospital, Clarksburg, West Virginia.**

Figure 1. Large radiolucent filling defect (F) in midportion of jejunum demonstrated by upper GI and small bowel series.

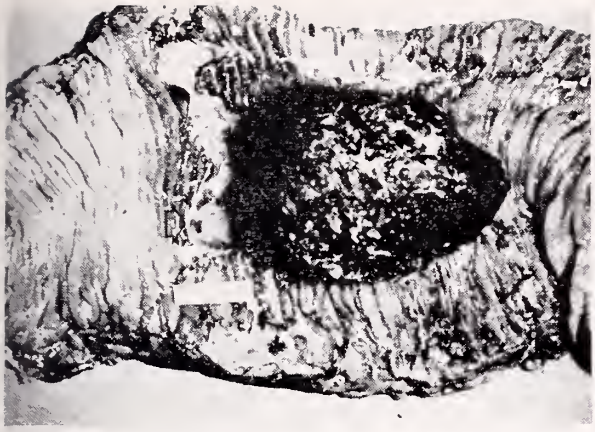

Figure 2a. Perforations and multiple ulcerations (arrow) posterior to and around the mass.

Figure 2b. Watermelon seeds enmeshed in necrotic debris, forming a fecalith measuring 7 x 5 x 4.5 cm.

barium going around this filling defect (Figure 1). Such a picture, it was felt, could be produced by a tumor or a retrograde intussusception.

On November 3, 1972, the patient underwent an exploratory laparotomy. There was a five by five centimeter mass palpable in the jejunum approximately two feet from the ligament of Treitz, and a perforation in the wall of the jejunum. Resection of the portion of the small bowel with the mass and an end-to-end anastomosis were carried out.

Pathological examination of the bowel revealed two perforations at the site of the mass. There were also multiple ulcerations beyond the perforations, measuring one to two and one-half cm. Section of the foreign body showed multiple seeds enmeshed in necrotic derbis (Figure 2).

The patient's postoperative course was uneventful and he was discharged on December 8 1972.

Comment

It is always difficult to diagnose intestinal obstruction due to food impaction prior to operation. Ward-McQuaid,[1] in 1950 reported 178 cases of intestinal obstruction due to food. Norberg, in 1962, reviewed over 300 cases with different foods listed as the cause of obstruction.

We have previously reported different types of seeds such as those of blackberry, watermelon, muskmelon and cherry as obstructive agents. X-rays of these previously reported cases, however, did not reveal a filling defect in the obstructed portion of the bowel.

A list of references may be obtained by writing The Journal.

Amniotic Membrane as Wound Dressing

RESEARCHERS in California are experimenting with amniotic membranes as a temporary dressing to relieve pain and stop infection of surface wounds. Dr. John D. Trelford, of the University of California at Davis, is experimenting with sheep and the amnion from the sacks of unborn lambs.

Doctor Trelford has found that the amnion blocks fluid loss, stops infection, relieves pain and allows healing to take place. This material remains alive up to eight days when used as a covering for surface wounds.

The amniotic membrane has been used successfully in plastic surgery of the female vulva, and as a temporary dressing for a burned child. The membrane may eventually be used as a standard application in the field of medicine, according to the National Society for Medical Research.

Medical Grand Rounds

From the West Virginia University Medical Center

Edited By

Raymond B. Weiss, M. D.
Assistant Professor of Medicine

Some Medical Aspects of Breast Cancer

Raymond B. Weiss, M. D.:

Breast cancer is the most common cancer in women and is the leading cause of death in women aged 39-54. The curative surgical approach for this disease was initiated in 1892 when Halsted developed the technique of radical mastectomy. Since then radical mastectomy has become the most frequently used primary procedure for the control of apparently localized disease. This procedure, however, recently has been challenged by many who say that doing something less than a radical mastectomy, with or without follow-up irradiation, is just as effective in curing disease and is associated with less morbidity.

Although a great deal of argument over the question has occurred, there never has been an adequate randomized trial of the various methods of treating primary breast cancer to provide an answer to the dispute. Such a trial involving multiple centers is getting underway currently with National Institutes of Health support.[1] Further, in spite of many modifications of the basic radical mastectomy that have been attempted to increase cure rates, no really significant increase in 50 years has occurred in the rate of cure of this disease. The reason is that the cancer has spread by hematogenous and lymphatic routes very early in a number of cases, before the time it is discovered and treated. So, no matter what sort of local therapy is used, the patient will still eventually manifest metastatic disease.

Since I don't want to get into the argument of the primary surgical management of breast cancer at Medical Grand Rounds, suffice it to say no one has definitive proof that one method is better than another, as yet. Hopefully, the large, multicenter study will answer this question.

The internist is becoming involved in the primary management of breast cancer in the selected patient who has four or more positive nodes at the time of her primary surgery. These patients have a very high risk of developing distant metastatic disease [2] and efforts are being undertaken to attack this problem by giving chemotherapy. Both the Acute Leukemia Cooperative Group B (ALGB), of which the West Virginia University Hospital is a member, and the National Surgical Adjuvant Breast Group now have protocols for giving long term chemotherapy to this select group to try to increase the cure rate and overall survival. The ALGB study compares giving single drugs versus combinations of drugs for a total of three years or until treatment failure has occurred.

We are now actively seeking patients who are eligible for this study and who are willing to participate. Since patients with four or more positive nodes at the time of surgery have an 80 per cent chance[2] of developing metastatic disease within five years, hopefully this incidence rate can be decreased and the overall survival enhanced.

One area of importance to the internist is the early diagnosis of this cancer. Part of the problem in the lack of change in the cure rate of primary disease is that, as I said, by the time the disease is biopsied and diagnosed, it is already beyond cure by surgery alone. Progress is being made in the diagnosis of this disease through the use of mammography in which small tumors are being detected very early, sometimes before they are even palpable by the surgeon. Doctor Gabriele will discuss this problem.

Orlando Gabriele, M. D., Chairman, Department of Radiology, West Virginia University Medical Center:

Mammography probably has done more to influence the diagnosis and treatment of breast carcinoma than any other procedure in recent years. Interest in clinical mammography started in the early 1930's but was later abandoned because of poor techniques and consequently poor results. There was a resurgence of interest and rapid expansion in the years following 1960, in large part due to the results of Dr. Robert Egan's studies.

Mammography is a radiographic representation of the soft tissues of the breast and its pathological states obtained by using "soft" x-rays. No contrast medium is utilized. The radiographic technique may be of the standard x-ray-film format or xeroradiology, which is an electronic imaging technique. Radiographic technique is of prime importance in obtaining mammograms of diagnostic quality and is dependent upon the appropriate combination of x-ray quality, radiographic film, and processing technique. Mammography supplements physical examination rather than replaces it, and its effectiveness is in part related to patient selection.

Important Radiographic Findings

Mammography consists of at least two and, preferably, three projections of the breast tissues. Interpretation of the results is enhanced by correlation with the clinical history and the physical findings. Several radiographic findings are of importance. Any increase in density may be of significance. A density not previously visualized on an antecedent examination may be a significant lesion. A dominant density different from the remaining architecture of the breast may represent a suspicious lesion. A density which is disproportionately small on radiographs as compared with palpatory findings also is a suspicious finding. A density with irregular borders and with straightening of the suspensory ligaments or connective tissue in the surrounding area represents a highly suspicious lesion. Calcification within the lesion and even without the presence of a gross mass lesion may be highly diagnostic in some circumstances. Not all calcifications are indicative of malignancy. Large, coarse and scattered calcifications, few in number often are related to benign processes. If the calcifications are very numerous and extremely fine, this is highly characteristic of carcinoma of the breast. Skin thickening overlying the lesion, distortion of the adjoining architecture, and enlargement of the vasculature of the surrounding tissues also are diagnostic findings of malignancy. Benign lesions often are sharply marginated and discrete. One must be certain, however, that the sharp margin extends around the entire periphery of the lesion on all projections. Occasionally, benign processes such as abscesses may simulate malignant processes. Inflammatory carcinoma of the breast may be difficult to distinguish from benign inflammatory disease.

Mammography is not 100 per cent accurate, especially with improper techniques. Diagnostic accuracy is related to the density of the breast with respect to that of the lesion. An atrophic breast with considerable replacement of the parenchyma with adipose tissue represents a situation in which lesions are more readily demonstrable and have a high degree of accuracy. Masses of various sorts are difficult to discern in young breasts in which there is relatively little adipose and considerable parenchyma. This is reflected in some of the figures relating to accuracy. In persons less than 30 years of age or during pregnancy, there is only a 50 per cent accuracy in diagnosing carcinoma of the breast whereas in patients over the age of 60 there is a 90 per cent accuracy in diagnosis.

The interpretative error in mammography is approximately five to ten per cent. Approximately 10 per cent of benign lesions may be misinterpreted as malignant lesions. On the other hand, approximately 10 per cent of carcinomas of the breast which are not detectable by usual physical diagnosis may be detected on mammography.

Mammography is of greatest value if applied to a selected population. In general, mammography should be utilized in patients over the age of 40 years, in those patients with a previous carcinoma of the breast, or in those patients with a family history of carcinoma of the breast. Mammography should be utilized also in breasts difficult to examine clinically and in situations in which metastatic adenocarcinoma has been detected but the site of origin is undetermined. Mammography should be utilized also when there is a dominant nodule palpated in the breast or there are other suspicious clinical findings.

Radiation exposure to the patient is well within acceptable levels and if the technique is applied to the population at risk as described above, it represents a negligible factor.

Mammography represents a highly accurate supplementary diagnostic technique in detecting carcinoma of the breast which if applied to a selected population has a very high yield and

has a very high degree of accuracy. Its accuracy is dependent upon precision of technique. The simplicity of this technique warrants its availability in most communities.

Doctor Weiss:

Only about 25 per cent of women will never have a recurrence after their initial therapy, be it surgery or radiation or both. Five year "cures" in breast cancer mean nothing as this disease is associated with a high frequency of late recurrences. I have personally seen a number of patients have their first evidence of metastatic disease occur from six to 15 years after their initial surgery.

Metastatic breast cancer is a frequent disease and an important disease in internal medicine, because these patients represent the largest number of adults with advanced malignancies that can be potentially influenced by various therapies. It is also a problem that occurs with fair frequency in younger women. Breast cancer can occur in women as young as their early twenties and in many women in their thirties. These periods are of course at the time when women have young children to care for and any enhanced survival that one can give may be very meaningful.

In contradistinction to lung cancer in which few therapeutic efforts affect the outcome, a great deal can be offered to women with metastatic breast cancer. Symptoms can be effectively palliated and survival can be significantly increased, sometimes for a number of years. Very few patients do not respond to any therapeutic modality.

For those patients in whose cases evidence of metastatic disease develops, the first treatment modality that should be considered is hormonal manipulation. It is, of course, obvious that breast growth and development are influenced by estrogenic hormone, and as far back as 1889 it was found that castration would aid in the treatment of young women with breast cancer. Since the 1890's this has been a standard therapy for premenopausal women who have metastatic disease. Further advances were made in the early 1950's with the introduction of bilateral adrenalectomy with cortisone replacement, by Huggins, and hypophysectomy by Perrault, in France.

Ablation of ovarian secretion results in approximately one-third of the premenopausal women having objective regression of tumor. In all my discussion of responses, I refer to objective responses only, meaning decrease in size of skin or nodal lesions, re-calcification of ossens metastases, or decrease in pulmonary nodules or liver size, and absence of progression of any lesion.

It is known that if a patient responds well to castration, and then estrogen is administered, there will be clinical evidence of stimulation of tumor growth. We know that two-thirds of the patients don't respond to castration. So the tumor can be estrogen-dependent or independent. If the tumor requires the presence of estrogen for growth, we eliminate the major source of estrogen, i.e., the ovary. If later on there is reactivation of the tumor, then growth is ascribed to estrogen produced by the adrenal glands, and this is then removed by adrenalectomy or indirectly by hypophysectomy. About 50 per cent of patients will respond to the second ablative surgery, if surgery is confined to castration responders.[3] It seems to make no difference whether hypophysectomy or adrenalectomy is done as both result in almost identical response rates and durations of response.[4]

Hypophysectomy as an additional procedure after adrenalectomy is not recommended, because the incidence and duration of remission do not justify employing an additional major surgical procedure.[5] For those patients who do not respond initially to castration, it is not worthwhile proceeding to major ablative surgery. Although there are occasional responders, again the incidence and duration of response do not make it worthwhile.

Castration is best accomplished by oophorectomy, but radiation can be used. Radiation, however, is much less satisfactory because the completeness of ovarian suppression frequently is in doubt, and it takes several months for complete ablation of function to occur.

In post-menopausal patients, ovarian function and estrogen secretion have ceased. In 1943, it was first shown that breast cancer in the postmenopausal patient will regress with estrogen administration. Since then numerous studies have confirmed the fact that approximately one-third of patients will have objective remission to this treatment.[6] This response rate gets even better when patients who are at least five years postmenopausal are selected out. Those patients who are within five years of menopause are frequently poor hormonal responders.

The tumor originally grows in an estrogen-poor environment and administration of estrogens causes regression. Why does this happen? It may be due to a direct inhibitory effect of the hormone on breast tumor tissue. There have been some studies showing inhibition of tumor growth in cell culture by a direct application of

high estrogen concentration.[7] Prolactin is an anterior pituitary hormone which is known to affect breast tissue growth. It is chemically similar to, but distinct from, growth hormone. It has been shown that administration of high doses of estrogen can decrease prolactin secretion and thus indirectly this may suppress tumor growth.[7] We can speculate why estrogen affects breast cancer, but as yet nobody has really shown conclusively why it works.

Going back to the estrogen-dependent hypothesis, it is assumed that when reactivation of tumor occurs after estrogen administration in the post-menopausal patient, the tumor has now become estrogen-dependent. So estrogen is now withdrawn. Some patients have tumor regressions when nothing else is done except to stop the estrogen. So now all estrogen is removed by stopping the drugs and then doing a hypophysectomy or adrenalectomy. This ablation is followed by a response in 70 per cent of the patients who responded to estrogens.[3] If only the good responders to initial hormone therapy, (i.e., those lasting six months or more) are selected out as the ones to do a major ablation on, the response rate can be even higher.

The standard dose of estrogen is to give diethylstilbestrol five mg. t.i.d. If one starts at this high dose initially, the patient will have a great deal of nausea and vomiting. It is thus recommended that one start out at five mg. per day, and gradually increase the dose to the 15 mg. as tolerance to the side-effects develops. Another estrogen side-effect of importance is stress incontinence. This is a drug effect and is not due to cystocele/rectocele.

Androgens have been known to influence the growth of breast cancer since 1939. Use of male hormone has been found to cause objective tumor regression in approximately 20 per cent of post-menopausal patients. Only 10 per cent or less of pre-menopausal women will have regressions.[6] This androgen response may be due to a direct effect on tumor growth, as has been shown in rat mammary tumors and in tumor cell cultures.[7] Androgen therapy, although causing a lesser frequency of responses, still is an effective treatment and can be used as an alternative at any time either for estrogen responders or non-responders. The androgenic hormone, of course, causes masculinizing side-effects which sometimes can be very distressing to the patient. The drug usually used is fluoxymesterone (Halotestin), 30 mg. daily.

When the patient's general condition is a contraindication for major ablative surgery, or she refuses, an alternative choice of therapy consists of large doses of adrenocorticosteroids. Although the incidence of regression is not as great and the duration not as long, adrenocorticosteroids can give a rapid subjective and objective improvement in some seriously ill patients.

If at any time the patient fails hormonal manipulation treatment, she becomes a candidate for chemotherapy. Hormonal therapy follows a fairly strict sequence and response rate and duration have been well established. A standard methodical approach to the use of chemotherapy in breast cancer, however, has not been developed as yet, because even after 20 years of using chemotherapy, the best drug or combination has not been found yet. The indications for chemotherapy are progressive disease with demonstrated unresponsiveness to hormonal manipulation or rapid progression of disease that precludes waiting the required two months for hormonal response observation.

Since breast cancer is such a common tumor, testing is done with every new anti-tumor agent, and chemotherapy with single agents has now been tried in a variety of ways with fairly consistent results. There is, however, still some variation in response rates between studies because of the variable natural growth of disease, the length of recurrence-free survival, and the responses to previous treatment. Table 1 shows

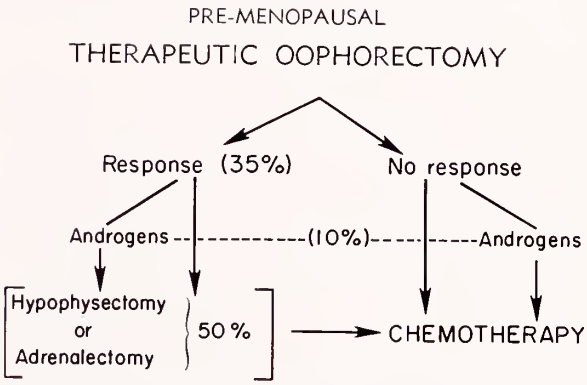

Figure 1. Summary of the sequence of therapeutic modalities for the premenopausal patient with breast cancer. Approximate response rates are in parentheses.

the conventional chemotherapeutic agents and their range of usual objective response rates.[8] The usual method of drug therapy is to start out using either Cytoxan or 5-FU as these two drugs have the best response and, if a response is obtained, then the drug is continued until it is no longer effective. Then another single agent is used. One can begin either with 5-FU or Cytoxan and go to the other if no response occurs.

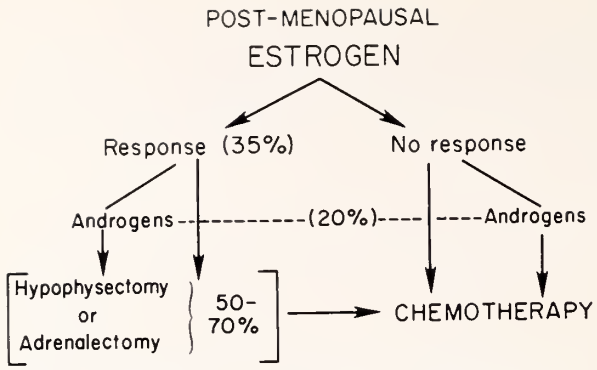

Figure 2. Summary of the sequence of therapeutic modalities for the postmenopausal patient with breast cancer. Approximate response rates are in parentheses.

Since the early 1960's when it was shown that a combination of drugs worked better than single agents in acute leukemia, chemotherapeutic trials have involved combinations in an attempt to achieve better regressions. It has now been well established that combination treatment is useful in acute leukemia and lymphomas. The same probably can be said of breast cancer.

Table 1.—Collected series results using single agent chemotherapy in breast cancer.

Single Agents	*Objective Response Rate*
1) Alkylating Agents: cyclophosphamide (Cytoxan), thio-TEPA, melphalan, nitrogen mustard	23 - 40%
2) Antimetabolites: 5-Fluorouracil	27 - 44%
3) Folic Acid Antagonist: Methotrexate	21 - 43%
4) Vinca Alkaloids: Vincristine, Vinblastine	20 - 34%

All four of the agents that are effective as single drugs with the addition of prednisone have been combined into a five-drug combination.[9] Results of use of this combination have varied from 63 to 88 per cent, so it is definitely better than any of the single agents alone. Eighty-eight per cent was the initial report in a small series and is thus a questionable figure.[9]

Data from the Acute Leukemia Group B[10] show a five-drug combination to be more effective than a three-drug combination in inducing remission and enhancing survival duration. Another group[11] confirmed this greater response with a five-drug combination than with single agents. Both groups had more toxicity with five drugs than with one or three drugs at a time, as one might suspect, including a few probable drug-related deaths. It has been argued that giving each drug in full dose as a single agent sequentially is no less effective in survival duration than giving the five-drug combination, and there is some evidence to support this idea.[12] All studies of this sort to date, however, do show enhanced survival for patients who respond compared with non-responders. Thus there is a definite benefit for the risk of chemotherapy. A new experimental drug, Adriamycin, has shown antitumor effectiveness in breast cancer. In several studies,[13] the response rate for Adriamycin as a single agent has been about 35 per cent. Adriamycin is a promising new therapeutic agent for breast cancer and should be considered for use in any patient who is a hormonal failure and a failure to conventional chemotherapy. Further studies are planned for including Adriamycin in combination with other drugs in the never-ending attempt to find something better for a now ultimately fatal disease.

To summarize I would like to make the following points:

(1) Hormonal therapy results in a high frequency of responses, and responders have a significantly longer survival. The first line of treatment should always be hormonal manipulation if possible. The menopausal status determines the initial therapy, be it estrogen therapy or estrogen ablation.

(2) The response to initial hormone treatment determines future therapy, and it is very important to measure and observe for hormonal response. It may take as long as two months for responses to occur, so treatment should be given for at least this time length. If the patient has rapidly progressive, life-threatening disease, then chemotherapy should be used and hormonal therapy abandoned as there is no time to wait.

(3) Central nervous system metastases respond poorly to hormonal therapy and should be treated with irradiation. Radiotherapy is very effective palliation for local disease and should be offered at any time for control of bone pain, prevention of pathologic fractures, or large skin lesions. Radiation may be used if the patient fails to respond to hormonal manipulation, or if for example the patient has several lesions that can be followed for hormonal response and one particularly symptomatic lesion that radiation can palliate.

(4) There are five chemotherapeutic agents which are effective in breast cancer, specifically, Cytoxan, Methotrexate, Vincristine, 5-FU and Prednisone. Adriamycin is the newest experimental drug with demonstrated effectiveness against this tumor.

A list of references may be obtained by writing The Journal.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide,' check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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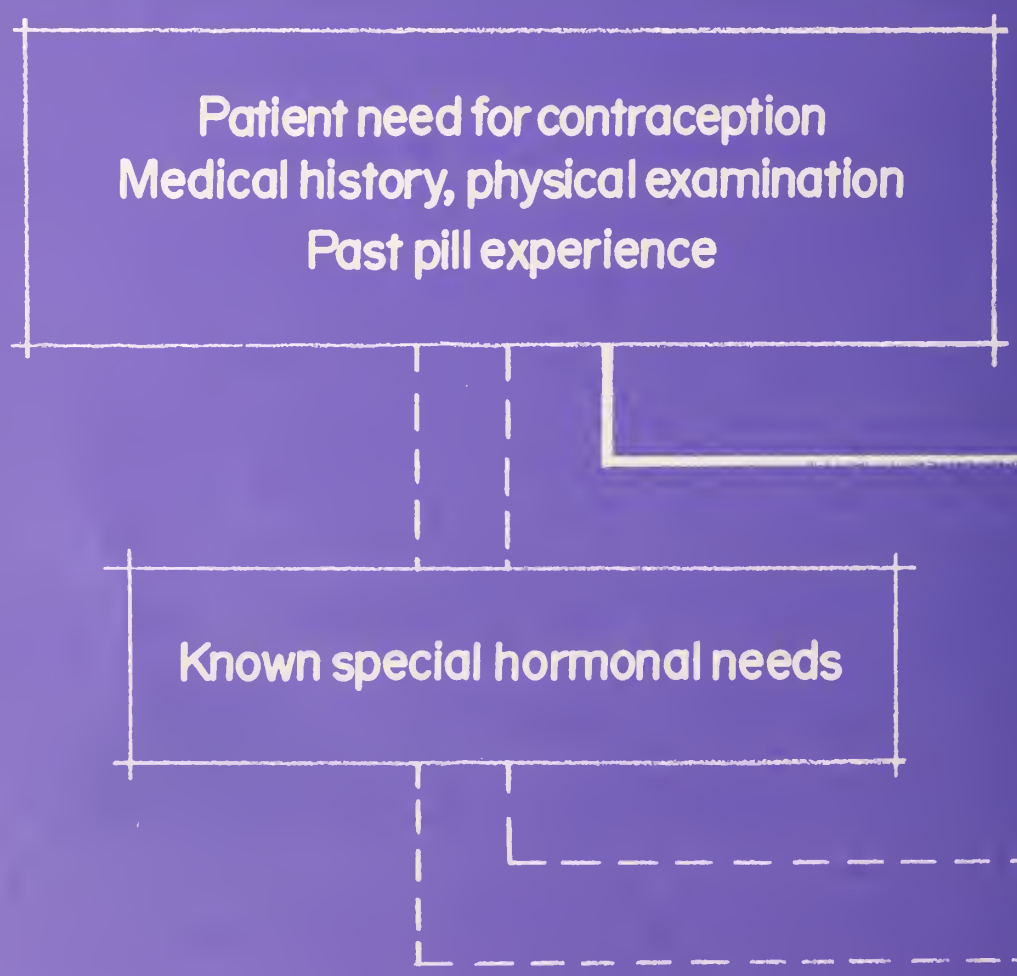

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primarily on animal studies.

Note: Oral contraceptives are complex medications. As with all medications they should be prescribed with discriminating care, and only after reference to full prescribing information. For brief summary of prescribing information, please see next page.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this facto such as epilepsy, migraine, asthma, cardiac or renal dysfunctio require careful observation. In breakthrough bleeding, and in a cases of irregular bleeding per vaginam, nonfunctional cause should be borne in mind. In undiagnosed bleeding per vagina adequate diagnostic measures are indicated. Patients with a hi tory of psychic depression should be carefully observed and th drug discontinued if the depression recurs to a serious degree. Ar possible influence of prolonged Ovulen or Demulen therapy on pit itary, ovarian, adrenal, hepatic or uterine function awaits furth study. A decrease in glucose tolerance has been observed in a si nificant percentage of patients on oral contraceptives. The mec anism of this decrease is obscure. For this reason, diabetic patien should be carefully observed while receiving Ovulen or Demule therapy. The age of the patient constitutes no absolute limiting fa tor, although treatment with Ovulen or Demulen may mask th onset of the climacteric. The pathologist should be advised Ovulen or Demulen therapy when relevant specimens are submi ted. Susceptible women may experience an increase in blood pre sure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contrace tives—A statistically significant association has been demonstrate between use of oral contraceptives and the following serious a verse reactions: thrombophlebitis, pulmonary embolism and cer bral thrombosis.

Although available evidence is suggestive of an association, suc a relationship has been neither confirmed nor refuted for the fo lowing serious adverse reactions: neuro-ocular lesions, e.g., retin thrombosis and optic neuritis.

The following adverse reactions are known to occur in patien receiving oral contraceptives: nausea, vomiting, gastrointestin symptoms (such as abdominal cramps and bloating), breakthroug bleeding, spotting, change in menstrual flow, amenorrhea durir and after treatment, edema, chloasma or melasma, breast chang (tenderness, enlargement and secretion), change in weight (i crease or decrease), changes in cervical erosion and cervical secr tions, suppression of lactation when given immediately post partur cholestatic jaundice, migraine, rash (allergic), rise in blood pre sure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported users of oral contraceptives, an association has been neither co firmed nor refuted: anovulation post treatment, premenstrual-li syndrome, changes in libido, changes in appetite, cystitis-like sy drome, headache, nervousness, dizziness, fatigue, backache, hi sutism, loss of scalp hair, erythema multiforme, erythema nodosur hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of or contraceptives: hepatic function: increased sulfobromophthalein r tention and other tests; coagulation tests: increase in prothrombi Factors VII, VIII, IX and X; thyroid function: increase in PBI ar butanol extractable protein bound iodine, and decrease in T^3 u take values; metyrapone test and pregnanediol determination.

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The *Special Note, Contraindications, Warnings, Precautions* a *Adverse Reactions* listed above for Ovulen and Demulen are app cable to Enovid-E and should be observed when prescribing Enovid-

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are pleased to announce

"The Seventh Mid-Winter Clinical Conference"

at the

Heart-O-Town Motor Inn
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Charleston, West Virginia

8 P.M. Friday, January 18
10 A.M. and 2 P.M. Saturday, January 19
10 A.M. and 1:30 P.M. Sunday, January 20

THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY EVENING, JANUARY 18, presentations will include Professional Standards Review Organizations (PSROs) and a session open to the public on the "battered child." A medically oriented battered child program will follow SATURDAY MORNING, JANUARY 19, with these other scheduled subject areas: SATURDAY AFTERNOON, diabetes, heart disease and hypertension; SUNDAY MORNING, JANUARY 20, cancer chemotherapy, drug interactions and arthritis; and SUNDAY AFTERNOON, chest disease, obstetrics and gynecology, urology and venereal disease control.

THE FACULTY will include outstanding specialists in their fields from various educational and other settings, both outside and from within West Virginia.

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M.D., and Joseph T. Skaggs, M.D., both of Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents; and will include admission to a group buffet luncheon on Sunday, January 20. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians planning to spend one or more nights in Charleston should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters inn setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. Va. 25324.

Please register me for the Seventh Mid-Winter Clinical Conference in Charleston, W. Va., January 18-20, 1974. My $15 registration fee is (is not) enclosed.

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A message from . . .

The President

UNITED FRONT A NECESSITY

In 1972 the House of Delegates at our Annual Meeting voted to support the concept of a medical foundation sponsored by the State Association pending support of the various component medical societies. There being no serious objections voiced by the counties, the House in 1973 then voted upon a resolution passed without a dissenting vote to lend our support to a medical institute. "Institute" being a more acceptable term since a foundation can be thought of perhaps as a medical care delivery system—our institute is primarily for educational and review purposes.

We have thus created an instrument independent of our federation which can proceed with the establishment of a Professional Standards Review Organization (PSRO) hopefully upon a statewide basis.

The government has yet to issue their guidelines nor have their boundaries been established. These will not be announced until December or January.

Briefly, a PSRO must be composed of physicians, including osteopathic physicians, and must be independent of organized medicine. The primary guidelines indicate that more than 300 but fewer than 2500 physicians may be involved in a single PSRO. The mission then of the PSRO is to review the quality, appropriateness and necessity of medical care.

Our mission now is to maintain our unity. By law, only physicians can perform the above review. The hospitals through organized staffs have performed some of the above functions with internal audits and utilization review. I can see no reason why some of these functions cannot be incorporated into our statewide plan.

But again let me emphasize the necessity of maintaining our unity. If we should allow ourselves the luxury of bickering among ourselves then the stage will be set for the total fragmentation in our federation. The insurance companies also have the resources and data base to initiate PSRO activities but again they have to have the doctors to provide the actual review.

So unity must continue to be the byword of our federation lest third parties usurp control.

Tom McCoy

A. Thomas McCoy, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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EDITORIALS

THE NEW PRESIDENT

The coming year promises to be a vital one for the medical profession throughout the country. The State of West Virginia is no exception and we can count our blessings we have strong leadership within the State Medical Association to cope with the problems confronting us.

Dr. A. Thomas McCoy was installed as President of the Association at the final session of the House of Delegates during the 106th Annual Meeting in White Sulphur Springs. In brief remarks before the delegates and guests he pledged an all-out effort on his part to organize a united front among the profession to guarantee that physicians play the leading role in the health care delivery system in West Virginia.

We believe the Charleston urologist will succeed in his call for greater unity. He is aggressive and possesses both the desire and energy to see that the job is accomplished.

Doctor McCoy grew up in Monroe County and he has never lost his love for that beautiful section of the State. Educated in the public schools of Monroe County, he went on to West Virginia University and was graduated from the two-year WVU School of Medicine. He received his M. D. degree in 1953 from the Medical College of Virginia in Richmond.

From that point on he has had an interesting and successful career in both his medical practice and in the affairs of organized medicine. We won't dwell further on his background in this space as a more complete biographical sketch may be found in the news section.

A. Thomas McCoy, M. D., President

Rather, we would like to applaud Doctor McCoy for his past work for the Association and pledge to him our cooperation in his call for strong unity within the ranks.

We also would like to praise the dedicated and hard work of the retiring President—Dr. Worthy W. McKinney of Beckley. The busy ophthalmologist spent many days on the road and in the air during the past year and gained many new friends for the Association.

Perhaps Doctor McKinney's finest achievement was his success in lining up our forces to be in a position to deal more effectively with the third-party agencies during the months ahead. He made clear his criticism of the policies of some of these agencies and offered suggestions for improvement. As Chairman of the Council we are sure he will continue to strive for needed changes in policy.

Everybody seemed to have a most enjoyable time at The Greenbrier this year even though the business agenda was much heavier than usual.

Doctor McCoy and the members of the 1973 Program Committee arranged scientific sessions which provided something of interest to all in attendance. They deserve much credit.

One final note of interest. Dr. J. Hugh Wiley of Morgantown, Chairman of the 1974 Program Committee, has announced that every effort possible will be made to keep Thursday and Friday afternoons open to enable those in attendance to enjoy the many recreational facilities available at The Greenbrier.

LOOKING FOR A PLACE TO PRACTICE? COME JOIN US

I parked my car in the hospital parking lot at 9:30 P.M. As I hastened to the delivery room, I saw a tall, attractive, neatly dressed blond approaching me on the sidewalk. When our paths crossed she broke into a spontaneous smile and greeted me. I returned the greeting, and thought to myself: "That is one of the reasons that I chose to practice medicine in West Virginia. The people are so friendly."

In some of the larger cities on the East Coast strangers would have passed like ships in the night too fearful or too preoccupied to speak; much less to give a warm smile.

When I was looking for a place to practice I liked the fact that the schools here were already completely integrated. We would not go through the trauma of bussing or anxiety of flight to private schools that has been the bane of some of the Southern cities.

I liked the fact that West Virginia has four seasons. Called the Mountain State, we are among the fortunate dwellers here who have a lovely view of one of those mountains. As Summer dwindles into Fall, we see her put on all the yellows, oranges and golds of Autumn. In Winter she resembles a stately woman who has visited the beauty shop to have her hair frosted. In Spring she dons her elfian green, and so back to Summer: four distinct seasons.

I liked the diversity of West Virginia's industry. If Chicago is "hog-butcher to the world," then West Virginia is glass maker to First Ladies and Royalty. How proudly did we take our Texas friends to see the glass heated, blown, shaped and cooled. How excitedly did they purchase these same lovely glass articles to take back home to Texas to show their friends.

Our life here orbits about the main pivots of church, community, school, home and hospital. These solid rocks give firm foundations in a century when many lives are aimlessly adrift.

Our children found warm friendly welcomes from their peers in the community. They became cheerleaders, club members and friends as West Virginians of their own age openly accepted them.

As a fellow physician seeking a place to practice, do you seek opportunities of recreation? Pipestem is one of the loveliest state parks anywhere in the United States. And should you desire a less formal park, Camp Creek State Park and Forest invites you to come picnicking, trout fishing or deer hunting in season. A few miles from Pipestem the annual aquapades are held at Bluestone Dam, which resembles some of the full color ads from Ireland showing lovely blue rivers framed by tall green mountains.

Do you seek challenge? Our state's physician/patient ratio is still one of the lowest in the nation: especially in some sections of the state. Because of this our infant mortality is still above the national level. Because of this certain diseases such as typhoid fever are still to be found.

Do you want to see progress? As I look at West Virginia, I see a State on the move with a multi-million dollar road building program, new regional health programs including a core of Emergency Medical Technicians, and a political leadership that has aroused itself from past lethargy.

So if you are a fellow physician seeking a place to practice, come and visit us. Come and

try Wild, Wonderful West Virginia! — *Guest Editorial by T. Keith Edwards, M.D., Member of the Staff, Department of Obstetrics and Gynecology, Bluefield Sanitarium, Bluefield, West Virginia.*

CARBON MONOXIDE POISONING

The winter months soon will be here and it is in these months that most cases of carbon monoxide poisoning occur. The danger of course lies in the fact that carbon monoxide has a strong affinity for hemoglobin, and, furthermore, carbon monoxide-hemoglobin is a relatively stable compound compared to oxyhemoglobin, and as a consequence dissociates much less easily than does oxyhemoglobin. In point of fact, even relatively small amounts of carbon monoxide in the inspired air, such as 0.1 of one per cent is dangerous, especially if the individual remains in this atmosphere for a long time for the carbon monoxide slowly builds up in the blood and gradually replaces the oxygen. In technical terms the carbon monoxide produces an anemic hypoxia, that is, the arterial blood contains oxygen at a normal tension but there is a shortage of functioning hemoglobin. In high concentrations carbon monoxide probably also may interfere with tissue oxidation, that is, it may also produce a histotoxic hypoxia.

The physician is acquainted with these facts, but most laymen are not aware of them and are quite unfamiliar with the dreadful sequelae which may occur following carbon monoxide poisoning. The scarcity of oxygen available due to the presence of carbon monoxide-hemoglobin may produce an irreparable injury to the cells of the central nervous system, especially the cells of the cerebral cortex. Drinker* pointed out many years ago that individuals who have suffered from severe carbon monoxide poisoning may be practically "decerebrated."

Not long ago a report appeared in the British Medical Journal (Feb. 10, 1973) concerning the morbidity from acute carbon monoxide poisoning; a three year follow-up study was made of 74 survivors. Gross neuropsychiatric changes attributable to the poisoning was found in eight patients; three of them committed suicide. Of the 63 patients alive at the end of the followup period the available records indicated that 21 showed a deterioriation of the personality, 27 reported a subsequent impairment of memory, and only eight showed an improvement in their condition. This is indeed a depressing report, but illustrates well the awful dangers subsequent to acute carbon monoxide poisoning.

The survival time of the cerebral cells in oxygen want is much less than those in the medullary centers or in the spinal cord. Unfortunately when the cells of the cerebral cortex, or for that matter, any nervous tissue cells, have suffered a severe hypoxia nothing can be done to restore their normal function. The effect produced is the same as if the cells had been surgically removed. A patient so afflicted may live a long while but leads a vegetative type of existence of mental dilapidation depending upon the amount of cell injury to the brain. There may be only a mild change in personality or a slight blunting of the intellectual processes, but any damage to the cells of the cerebral cortex is a great catastrophe to the individual.

So far as treatment for carbon monoxide poisoning is concerned, the patient should, of course, be allowed to breathe normal air as quickly as possible. The carbon monoxide is gradually eliminated from the body. If the patient is allowed to breathe pure oxygen, elimination of carbon monoxide will be hastened, and if breathing pure oxygen under pressure can be provided (hyperbaric oxygenation) the elimination will be further hastened. The cerebral cells which have been permanently damaged cannot, of course, be restored to normal function as has been emphasized. Time and time alone will tell how much permanent damage the cerebral cells sustained.

The factor about which something can be done is the prevention of carbon monoxide poisoning. The public should be warned of the extreme danger of starting an automobile in a closed garage; it should be warned against gas leaks in the house, such as poorly adjusted gas heaters and also to check on any obstruction in the chimney. And finally, the public should be made aware of the dreadful sequelae which may occur following exposure to severe carbon monoxide poisoning. If proper and reasonable precautions are taken, carbon monoxide poisoning can practically be eliminated.

*C. K. Drinker. *Carbon Monoxide Asphyxia*, p. 133. New York: Oxford University Press (1933).

Did You Know?

Some 60 million Americans are protected by some form of "short term" protection against loss of income in case they are disabled. Of this number, two-thirds have disability insurance through insurance companies while one-third have paid sick leave coverage. Some 13 million Americans had "long term" protection at the beginning of the year.

GENERAL NEWS

Dr. A. Thomas McCoy Assumes Association Presidency

Dr. A. Thomas McCoy, a Charleston urologist, was installed by the West Virginia State Medical Association as its President at the concluding session of the House of Delegates during the 106th Annual Meeting Saturday, August 25, at The Greenbrier in White Sulphur Springs.

The convention began with Council and House of Delegates sessions on Wednesday, August 22. Registration totaled 644 and included 380 physicians.

Doctor McCoy was installed by Dr. Worthy W. McKinney of Beckley, the retiring President who had delivered his traditional address a few moments earlier. The text of the address appears in the scientific section of this issue of *The Journal.*

Doctor McKinney automatically became Chairman of the Council for the new Association year, succeeding Dr. Harry S. Weeks, Jr., of Wheeling.

Other New Officers

Elevated to President Elect from Vice President was Dr. William E. Gilmore, a Parkersburg surgeon who will assume the Presidency at the 1974 meeting, also scheduled by the Council for The Greenbrier next August 21-24.

Dr. Jack Leckie of Huntington was elected Vice President and Dr. Kenneth G. MacDonald of Charleston was re-elected to his ninth one-year term as Treasurer. A family physician, Doctor Leckie currently is Director of Emergency Services at St. Mary's Hospital in Huntington. Doctor MacDonald is a surgeon.

Dr. Frank J. Holroyd of Princeton was named to a new two-year term as a Delegate to the American Medical Association, with Dr. George R. Callender, Jr., of Charleston, re-elected as an Alternate Delegate.

Six new Council members were elected, with two other physicians re-elected to two-year terms. The new members are Drs. Robert R. Weiler of Wheeling, Robert D. Hess of Bridgeport, Robert W. Bess, Jr., of Piedmont, Louis W. Groves, Jr., of Richwood, J. L. Mangus of Charleston and Harold N. Kagan of Huntington.

Re-elected were Drs. Charles E. Andrews of Morgantown and John J. Mahood of Bluefield.

Holdover Councilors whose terms will expire in 1974 are Drs. Robert G. Janes of Fairmont, Robert R. Pittman of Martinsburg, L. H. Nefflen of Elkins, F. Lloyd Blair of Parkersburg, W. Alva Deardorff of Charleston, Richard G. Starr of Beckley and Thomas P. Long of Man.

Dr. A. Thomas McCoy (right) of Charleston is congratulated, in the left photo above, by Dr. Worthy W. McKinney of Beckley after being sworn in as President of the West Virginia State Medical Association at the final House of Delegates session during the State Medical Association's Annual Meeting at The Greenbrier. At the right, prior to the opening of the first meeting of the House of Delegates are, from left, Doctor McCoy, Dr. Russell B. Roth, President of the American Medical Association and the principal speaker; Doctor McKinney and Dr. Harry S. Weeks, Jr., of Wheeling.

Dr. Richard E. Flood of Weirton is a holdover Delegate to the AMA, with Doctor Weeks as holdover Alternate .

The President

Doctor McCoy was born in Bluefield and was educated in the public schools of Monroe County. Following graduation from high school, he served for two years with the U. S. Air Corps. He was graduated from West Virginia University and received a B.S. degree in 1951 from the two-year WVU School of Medicine.

The new President received his M. D. degree in 1953 from the Medical College of Virginia in Richmond and served an internship at the MCV Hospital, 1953-54. He served a residency at Charleston Memorial Hospital, 1954-55, and then was engaged in family practice in Bluefield and Stone, Kentucky from 1955 to 1959.

Doctor McCoy entered residency training in urology in 1959 at Watts Hospital in Durham, North Carolina, and completed his residency at the University of North Carolina in Chapel Hill in 1962.

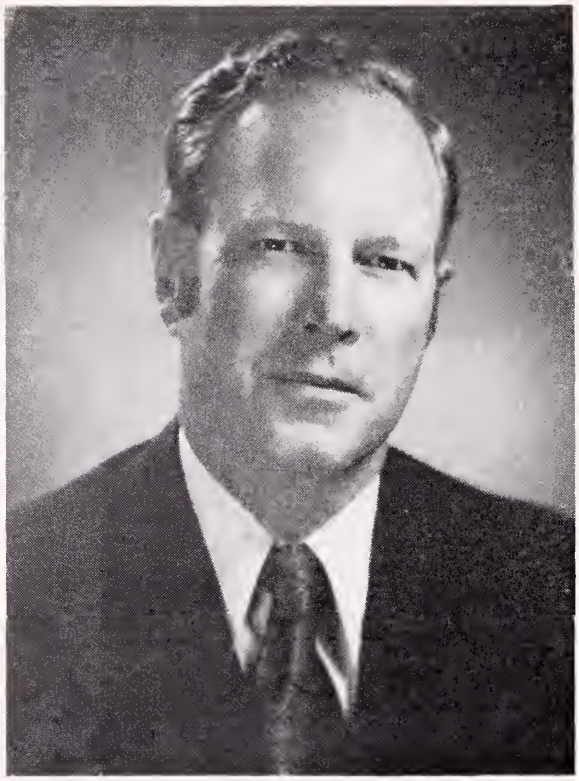
Following his residency training, Doctor McCoy returned to Charleston to engage in the private practice of urology. He is certified by the American Board of Urology and is a Fellow of the American College of Surgeons. He currently is serving as a member of the Executive Committee of the Mid-Atlantic Section of the American Urological Association.

In the State Medical Association, Doctor McCoy has served as a member of the Council, Vice President and President-Elect. He also is a Past President of The Kanawha Medical Society.

Doctor McCoy and his wife, the former Margaret Ann Wiley of Charleston, are the parents of two daughters and one son.

The President Elect

Doctor Gilmore, a native of Wheeling, received his undergraduate degree from West Virginia University and his M. D. degree in 1943 from the University of Wisconsin. He interned at Philadelphia General Hospital and served a residency in general surgery at the State of Wisconsin General Hospital. Doctor Gilmore is certified by the American Board of Surgery, and is a member of the American College of Surgeons, International College of Surgeons, Southeastern Surgical Congress and American Society of Abdominal Surgeons.



William E. Gilmore, M. D.
President Elect

Active in the Parkersburg Academy of Medicine, Doctor Gilmore was a member of the State Medical Association's Council from 1966-70. He is a member of the Committee on Medical Education and Hospitals and through that committee served as Chairman of the State Medical Association's survey team for accreditation of the continuing medical education program at Beckley Appalachian Regional Hospital this past spring — the first survey to be conducted under the Association's new CME accreditation program. He also is a member of the Cancer Committee.

The Vice President

A native of Toler, Kentucky, Doctor Leckie received his undergraduate degree from Marshall University and his M. D. degree in 1950 from the George Washington University School of Medicine. He served his internship at the United States Marine Hospital in New Orleans.

He is a Past President of the Cabell County Medical Society, the West Virginia Chapter of the American Academy of Family Physicians and St. Mary's Hospital. He also has served as a member of the Board of Trustees of Cabell-Huntington Hospital.

Dr. J. Hugh Wiley To Head 1974 Program Committee

The Program Committee for the West Virginia State Medical Association's 107th Annual Meeting at The Greenbrier August 21-24, 1974, will have Dr. J. Hugh Wiley of Morgantown as its Chairman.

Other Committee members are Drs. John T. Chambers of Charleston, Philip M. Sprinkle of Morgantown, William E. Gilmore of Parkersburg, Ray M. Kessel of Logan, and Winfield C. John of Huntington.

The Committee held a short initial meeting at The Greenbrier on August 24, and another session was scheduled to be held on September 30.

Doctor Leckie, who served three years on the State Medical Association's Council, also is a member of the Legislative Committee and the Medical Education and Hospitals Committee.

Dr. Hoffman and Gov. Moore Honored

The "First Distinguished Service Award" was presented by the State Medical Association to Dr. Charles A. (Carl) Hoffman of Huntington at the initial meeting of the House of Delegates on Wednesday afternoon, August 22. The new award was presented to Doctor Hoffman in recognition of his leadership as President of the American Medical Association in 1972-73 and "as an expression of sincere appreciation and deep affection from his fellow physicians throughout this State."

During its initial session the House of Delegates also commended Governor Arch A. Moore, Jr., and the West Virginia Legislature for assistance in financing post-doctoral medical education by making available the sum of $300,000 to the teaching hospitals of the State.

Both actions were taken in the form of resolutions which were passed unanimously by the House of Delegates. The resolution commending Governor Moore was presented to him by Doctor McCoy following the Governor's address during Opening Exercises on Thursday morning. Copies of the resolution also were to be forwarded to the Clerks of the West Virginia Senate and House of Delegates.

AMA-ERF Contribution

Doctor McKinney presented Dr. John E. Jones, Acting Dean of the West Virginia University School of Medicine, with a check for $13,436 at the initial House of Delegates session on Wednesday afternoon, August 22.

This represented an annual contribution by West Virginia physicians and Woman's Auxiliary members to the School of Medicine through the Education and Research Foundation of the American Medical Association.

Resolutions

At its second and final business session on Saturday, August 25, the House of Delegates adopted resolutions that:

- Reaffirmed the West Virginia State Medical Association's position calling for designation of the State as a single Professional Standards Review Organization (PSRO) area. Also supported the con-

The State Medical Association installed these officers at its Annual Meeting, with those seated, from left: Drs. A. Thomas McCoy of Charleston, President; William E. Gilmore, Parkersburg, President Elect; Jack Leckie, Huntington, Vice President; Kenneth G. MacDonald, Charleston, reelected Treasurer and George R. Callender, Jr., Charleston, reelected as an Alternate Delegate to the American Medical Association. Standing, from left, Drs. Robert D. Hess of Bridgeport, Robert R. Weiler, Wheeling; Louis W. Groves, Jr., Richwood; J. L. Mangus, Charleston, all newly elected members of the Council; and John J. Mahood, Bluefield, reelected to the Council. Other new Council members not shown are Drs. Robert W. Bess, Jr., of Piedmont and Harold N. Kagan, Huntington. Also not shown are Drs. Frank J. Holroyd of Princeton, reelected to a new two-year term as an AMA Delegate; Richard E. Flood, Weirton, holdover AMA Delegate and Harry S. Weeks, Jr., Wheeling, holdover Alternate AMA Delegate.

Governor Arch A. Moore, Jr., in the left photo, greets well-wishers following his address during Opening Exercises for the Annual Meeting. On the right, Dr. Worthy W. McKinney of Beckley, the State Medical Association's 1972-73 President, presents to Dr. John E. Jones, Acting Dean of West Virginia University's School of Medicine, a check for $13,436 representing contributions to the school by West Virginia physicians and their wives through the Education and Research Foundation of the American Medical Association.

tinued development and implementation of the West Virginia Medical Institute, Inc., as an independently incorporated, non-stock, non-profit corporation to contract with the U. S. Department of Health, Education and Welfare to carry out PSRO activities in West Virginia and to operate related educational and other programs within the scope of its authority.

- Gave the Council of the State Medical Association the responsibility of instructing the Delegates from West Virginia how to vote on key issues before the House of Delegates of the AMA.
- Increased from two to four the number of $4,000 scholarships awarded annually by the Association to students entering the WVU School of Medicine.
- Expressed "grave reservations" concerning PSRO legislation, recognizing that "repeal or modification ultimately may be required to preserve the high quality of patient care." The State Medical Association also was directed to oppose any facets of current PSRO legislation which might bring deterioration of quality of care.
- Citing the need for increased continuing medical education opportunities and support in West Virginia, endorsed and called for the prompt establishment of area health education centers throughout the State by the West Virginia University School of Medicine. It was stated that these centers should use the Charleston Area Health Education Center as a model and should emphasize continuing education for all health professions.
- Urged that, in connection with development of a new central mental health complex in the Sissonville area near Charleston, Governor Arch A. Moore, Jr. and other State officials "consult with

Shown in the left photo above as they attended the President's Reception on the first evening of the State Medical Association's Annual Meeting are, from left, Drs. Joe N. Jarrett of Oak Hill, Clark K. Sleeth, Morgantown; and Seigle W. Parks, Charleston. At the right are Governor Arch A. Moore, Jr. (left) and Dr. Worthy W. McKinney of Beckley prior to the Governor's address.

appropriate physicians, health administrators and educators regarding good utilization of existing health resources in order to insure comprehensive health planning." Such requested action was recognized as essential for further improvements in patient care and more effective residency training programs in psychiatry. Copies of the resolution (No. 8) were to be forwarded to Governor Moore, the Director of the Department of Mental Health, the Director of Comprehensive Health Planning and to the Clerks of the West Virginia Senate and House of Delegates.

Reception For Honor Guests

A reception was held on Wednesday evening, August 22, for honor guests. In addition to scheduled speakers, other out-of-state guests included:

Dr. W. J. (Jack) Lewis of Dayton, Ohio, Chairman of the Board of Directors of AMPAC; Mr. William L. Watson of Chicago, Executive Director of AMPAC; and Mr. and Mrs. James A. Waggener (Mr. Waggener is Executive Secretary of the Indiana State Medical Association).

Presidents of neighboring state medical associations and their wives included Dr. and Mrs. James H. Gosman of Indiana, Dr. and Mrs. Lee C. Hess of Kentucky, Dr. and Mrs. William Carl Ebeling of Maryland, Dr. and Mrs. Oscar W. Clarke of Ohio, Dr. and Mrs. Robert S. Sanford of Pennsylvania, Dr. and Mrs. Carl E. Stark of Virginia and Dr. and Mrs. Willard C. Scrivner of Illinois (Mrs. Scrivner is President of the Woman's Auxiliary to the AMA).

Other guests were Dr. and Mrs. Thomas McGuire of New Castle, Delaware, and Dr. and Mrs. Erle E. Wilkinson of Nashville, Tennessee. Doctor McGuire was a long-time member of the AMA House of Delegates and is an AMA Past Vice President. Mrs. Wilkinson is President of the Woman's Auxiliary to the Southern Medical Association.

Among honor guests, and the principal speaker at the opening House of Delegates Session on August 22, was Dr. Russell B. Roth, President of the American Medical Association.

Dr. Hoffman And Governor Moore Honored By Association

Dr. Charles A. (Carl) Hoffman of Huntington and Gov. Arch A. Moore, Jr., were honored by the West Virginia State Medical Association during its 106th Annual Meeting August 22-25 at The Greenbrier in White Sulphur Springs.

Doctor Hoffman was presented the State Medical Association's first "Distinguished Service Award" in recognition of his service as President of the American Medical Association during 1972-73. The Award was presented in the form of a resolution which was passed unanimously at the first meeting of the State Medical Association's House of Delegates on Wednesday, August 22. The text of the Resolution follows:

WHEREAS, The West Virginia State Medical Association has been favored by having as a member, an individual who, as President of the American Medical Association, has led this nation's physicians; and

WHEREAS, His dedication and service to organized medicine has been of inestimable benefit to all physicians; and

WHEREAS, It is our desire to recognize him as an outstanding person held in the highest esteem,

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association confer the first "Distinguished Service Award" of the West Virginia State Medical Association upon Charles A. (Carl) Hoffman, M. D., as an expression of sincere appreciation and deep affection from his fellow physicians throughout the State.

Governor Moore and the West Virginia Legislature were commended for initiating "an innovative and farsighted" program of financing postdoctoral medical education by making available the sum of $300,000 to the teaching hospitals of West Virginia. This action also was taken in the form of a resolution which was passed unanimously at the first session of the House of Delegates.

The resolution was presented to Governor Moore by Dr. A. Thomas McCoy of Charleston, President of

Dr. George R. Callender, Jr., (left) of Charleston visits with Dr. and Mrs. Robert S. Sanford at the Annual Meeting in the left photo. Doctor Sanford is President of the Pennsylvania State Medical Association. In the center photo, Governor Moore greets Dr. A. T. Gordon of Spencer (center) and Dr. Aaron D. Cottle, Spencer. In the right photo, Dr. Willard C. Scrivner (left), President of the Illinois State Medical Society, chats with Dr. Lee C. Hess, President of the Kentucky State Medical Association.

the West Virginia State Medical Association, following the Governor's address during Opening Exercises on Thursday morning, August 23. Following is the complete resolution:

Resolution No. 1—Commending Governor Moore and the West Virginia Legislature.

WHEREAS, The State of West Virginia embarked upon an innovative and farsighted program of financing post-doctoral medical education by making available the sum of $300,000 to the teaching hospitals of our State; and

WHEREAS, These programs, although expensive, are essential to the citizens of this State; and

WHEREAS, The State of West Virginia is thus relieving its sick and disabled from the burden of these costs,

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association does applaud and officially commend Governor Arch A. Moore, Jr., and the West Virginia Legislature for this enlightened and compassionate approach to increasing the number and quality of physicians available to West Virginia citizens, and

BE IT FURTHER RESOLVED, That a copy of this resolution be presented to Governor Moore during the 1973 Annual Meetng of the West Virginia State Medical Association at The Greenbrier and that copies be forwarded to the Clerk of the West Virginia Senate and the Clerk of the West Virginia House of Delegates.

Physicians Reappointed To State Boards

Two physicians were listed among appointments to state bodies announced recently by Governor Arch A. Moore, Jr.

Charles A. (Carl) Hoffman, M.D. of Huntington was reappointed to a five-year term on the Medical Licensing Board of West Virginia, expiring June 30, 1978.

Russel Kessel, M.D., of Charleston was reappointed to a seven-year term on the Advisory Board to the State Board of Health, expiring June 30, 1980.

Affiliated Societies, Sections Elect New Officers

A number of scientific sections, associations and societies affiliated with the West Virginia State Medical Association elected new officers at sessions during the Association's Annual Meeting at The Greenbrier:

The groups and officers include:

West Virginia District Branch, American Psychiatric Association—Drs. Thomas S. Knapp, Charleston, reelected President, and Miroslav M. Kovacevich, Charleston, Secretary-Treasurer.

Section on Urology—Drs. Harold N. Kagan, Huntington, reelected President, and James W. Lane, Charleston, reelected Secretary-Treasurer.

Section on Neurology, Neurosurgery and Psychiatry—Drs. O. Lee Trick, Charleston, President, and Arthur L. Poffenbarger, Charleston, Secretary.

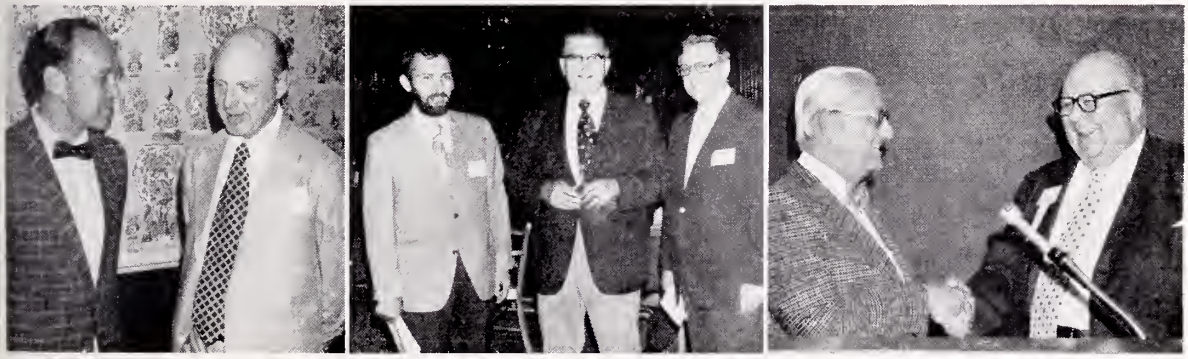
Section on Orthopedic Surgery—Drs. Robert W. Lowe, Huntington, President; Robert L. Ghiz, Charleston, Vice President, and Arthur A. Abplanalp, Charleston, reelected Secretary-Treasurer.

West Virginia Chapter, American Society of Internal Medicine—Drs. Leo H. T. Bernstein, Martinsburg, reelected President, and Frank J. Jarsen, Martinsburg, Secretary-Treasurer.

Section on Internal Medicine—Dr. Harold Selinger, Charleston, Chairman.

Section on Pediatrics and West Virginia Chapter, American Academy of Pediatrics—Drs. Barbara Jones, Morgantown, Chairman; R. J. Bailey, Parkersburg, Alternate Chairman, and Norah Gutrecht, Morgantown, Secretary-Treasurer.

West Virginia Radiological Society, Inc.—Drs. Joseph N. Aceto, Wheeling, President; James T. Smith, Charleston, Vice President, and Andrew W. Goodwin, Charleston, reelected Secretary-Treasurer. Drs. Arthur E. Levy of Williamson and Orlando F. Gabriele, Morgantown, are Counselor and Alternate Counselor, respectively.



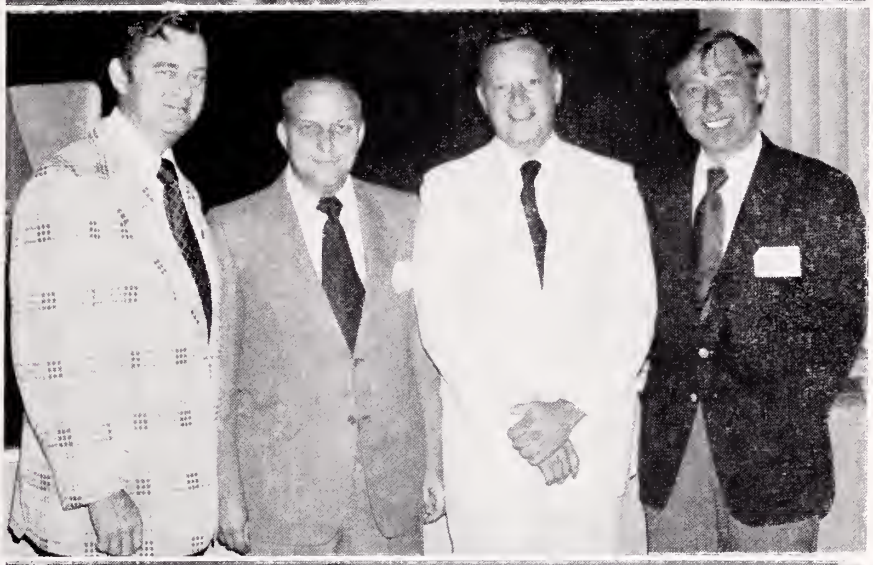
In the left photo, Dr. Philip M. Sprinkle of Morgantown (right), who presided at an afternoon open meeting during the annual meeting, talks with the speaker, Mortimer M. Caplin, Washington, D. C. Shown in the center photo are, from left, Drs. Joseph B. Reed of Buckhannon, Carl B. Hall, Charleston; and James L. Grobe, Phoenix, Arizona. In the right photo, Dr. William A. Sodeman (left) of Philadelphia, guest speaker for another open meeting, is greeted by Dr. Richard E. Flood, Weirton, who presided.

Posing for a photograph is the family of Dr. A. Thomas McCoy, President of the West Virginia State Medical Association, during a reception honoring officers at the Association's Annual Meeting. From left, are Doctor McCoy's daughter, Miss Frances Wiley McCoy; Mrs. Margaret (Maggie) McCoy; Doctor McCoy; son, Hugh; Doctor McCoy's mother, Mrs. Margaret Ballard McCoy, and daughter, Miss Nancy Ballard McCoy.

Dr. William H. Carter (standing) of Charleston, who served as Moderator, is shown with the speakers for the first scientific session at the State Medical Association's Annual Meeting. Seated, from left, are Drs. James J. Morris, Jr., of Durham, North Carolina; William H. Muller, Jr., Charlottesville, Virginia; and C. Richard Conti, Baltimore, Maryland.

Dr. Charles A. (Carl) Hoffman (right) of Huntington presided at a "Seminar on the Causes and Prevention of Malpractice Claims" held during the Annual Meeting. The speakers were staff members of Aetna Casualty and Surety, Administrator for the Group Liability Insurance Program for the State Medical Association. Shown here, they are, from left, F. M. Taylor, Edward Morgan, D. John Pecorino and Dr. David C. Kellsey.

Guest speakers (seated) for one of the scientific sessions at the Annual Meeting are shown here. From left, are Drs. Richard W. Lindsay of Charlottesville, Virginia; James L. Grobe, Phoenix, Arizona; and Wyn Rhys-Jones, Ottawa, Canada. Also participating were (standing, from left) Drs. J. Hugh Wiley of Morgantown, Robert G. Janes, Fairmont; and Clark K. Sleeth, Morgantown, Moderator.



Posing for a photograph at a scientific session are, from left, Dr. Alvin L. Watne of Morgantown and Dr. Theodore M. King, Baltimore, Maryland, both speakers; Dr. C. Richard Daniel of Beckley, Moderator; and Dr. John A. Kirkpatrick, Jr., Philadelphia, the third speaker.

Members of the State Medical Association's Publication Committee and a guest are shown after a luncheon during the Annual Meeting. Seated, from left, are Drs. Thomas J. Holbrook of Huntington, George F. Evans, Clarksburg, Editor of The Medical Journal; and Worthy W. McKinney, Beckley, the State Medical Association President for 1972-73. Standing, from left, Drs. Vernon E. Duckwall, Elkins; John M. Hartman, Charleston; Joe N. Jarrett, Oak Hill; and Stephen D. Ward, Wheeling. Not shown is Dr. E. J. Van Liere, Morgantown, The Journal's other Associate Editor.

Medical Association Urges State PSRO Structure

The West Virginia State Medical Association offered a strong argument at an August 16 meeting in Charleston for designation of West Virginia as a single, statewide area for implementation of Professional Standards Review Organization (PSRO) legislation enacted by Congress last year.

The Secretary of the U. S. Department of Health, Education and Welfare must designate by January 1, 1974, the geographic areas in which the new review activities will be established, and meetings have been arranged in each of the states to obtain recommendations from physicians and other groups relative to such designations.

Dr. George C. Gardiner, the U. S. Public Health Service's Region III Director with offices in Philadelphia, conducted the Charleston meeting. He received written or orally expressed support for the Medical Association position from a number of other sources.

Those included the West Virginia Society of Osteopathic Medicine; the West Virginia University Medical Center; the West Virginia Hospital Association; the West Virginia Regional Medical Program; the West Virginia State Health Department, and the Executive Director of the Comprehensive Health Planning "B" Agency in the Wheeling area.

The only recommendation varying from the statewide PSRO proposal came from the staff of the West Virginia Comprehensive Health Planning Agency, which suggested four review areas representing combinations of the State's 11 planning and development regions.

Harry A. Stansbury, Jr., Ph.D., the State CHP director, noted, however, that there might not be adequate numbers or distribution of specialists to make such an alignment practical. He suggested a north-south arrangement as his staff's second alternative, but agreed that there would be "many advantages in a central administrative structure."

The PSRO legislation creates a nationwide network of locally based physician groups to review the necessity, quality and appropriateness of hospital and other institutional care provided Medicare, Medicaid and Maternal and Child Health Program patients.

The best current information indicates that at least some of the area determinations will be announced by HEW prior to December 1—and that will clear the way for the next step in implementation of the law, the contracting with physician groups in the respective areas as organizations to initiate the professional review on a 24-month conditional basis.

Here is the text of the Medical Association's August 16 statement, which was offered by Dr. Harry S. Weeks, Jr., of Wheeling, in his role as Chairman of the Association's Council:

"I am Harry S. Weeks, Jr., M. D. I am in the practice of anesthesiology in Wheeling, West Virginia; I am the immediate past President of the West Virginia State Medical Association, and I am currently Chairman of the Association's governing Council.

"We appreciate the opportunity to meet here today with representatives of the U. S. Department of Health, Education and Welfare's Region III office, and others interested in implementing the Professional Standards Review Organization (PSRO) legislation. We are particularly grateful for this chance to make the West Virginia State Medical Associa-

Mrs. J. Dennis Kugel (right) of Charleston accepts the gavel from Mrs. Robert G. Janes of Fairmont in the left photo above as she succeeds Mrs. Janes as President of the Woman's Auxiliary to the West Virginia State Medical Association. In the right photo are new officers of the Auxiliary, with those seated, from left, including: Mrs. Janes, Parliamentarian; Mrs. J. L. Mangus, Charleston, Treasurer; Mrs. Kugel; Mrs. W. T. Lawson, Fairmont, President Elect. Standing, from left, Mrs. D. Sheffer Clark, Huntington, Western Regional Director; Mrs. Claude S. Lawson, Jr., Fairmont, Recording Secretary; Mrs. E. G. Friera, Romney, Eastern Regional Director; and Mrs. John J. Bryan, Bluefield, Southern Regional Director. Not shown are Mrs. James H. Walker, Charleston, Vice President; Mrs. J. D. H. Wilson, Clarksburg, Northern Regional Director; and Mrs. W. Paul Elkin, Charleston, Corresponding Secretary.

tion's ideas and recommendations known with respect to the upcoming designation of PSRO areas.

"As far as PSRO area designation for West Virginia is concerned, the position of the State Medical Association can be set forth in very few words.

"We wholeheartedly urge that the State of West Virginia, as such, be designated as a PSRO area, with a single PSRO organization to act as the contracting agent with Health, Education and Welfare to provide and assure the review services required by law.

"As a part of its overall management and administrative responsibilities, this PSRO can develop and constantly monitor such local mechanisms for actual review that can provide the most consistent, effective and economical results. We emphasize that this approach will fall clearly within a key intent of the PSRO legislation—that there be the largest local involvement of practicing physicians in the review process on a rotating basis. In West Virginia, the majority of practicing physicians will have to be involved in review if this program is to operate at all.

"More specific support for the statewide PSRO concept is not difficult, we feel, to establish and document. First, we are a small state from virtually any comparable standpoint, with some 1,750 practicing doctors of medicine and osteopathy. We, as a Medical Association in this state, perhaps are more aware than many of our counterparts elsewhere that the physicians are the ones that must make PSRO work.

"Without their all-out cooperation, and a united determination to meet a challenge that frankly is almost too awesome to comprehend, this program is doomed to fail. But West Virginia doctors, largely because of their small numbers, have had to face many challenges— and to collect resources which might prove sparse, particularly in some specialty areas, to overcome many obstacles.

"We think West Virginia physicians also can meet the challenge of PSRO—but we insist in all honesty that we must be given the opportunity to develop this program along lines we are confident, from past experience, are most workable. If we fail, then we, alone, shall be to blame. But we don't intend to fail.

"We are certain, in further support of the statewide PSRO concept, that we can proceed more quickly and smoothly, and certainly in a more economical manner, by traveling this route. We have been at work for almost two years on development of a separate medical foundation, or institute, structure with a medical education base. Designed to assure voluntary participation of all licensed, practicing doctors of medicine and osteopathy in the state, this institute is viewed as a practical PSRO vehicle.

"Its Articles of Incorporation now are in virtually final form, and so are its By-Laws. Its initial educational base is particularly important now from two standpoints. First, Senator Wallace Bennett insisted that the U. S. Finance Committee, in developing the PSRO legislation, recognize that major emphasis must be on education and not sanctions. Senator Bennett reemphasized this point at the annual meeting of the American Society of Internal Medicine earlier this year. Second, we are convinced that the proposed West Virginia Medical Institute, Inc., with its statewide structure, will be best equipped to respond, from an educational standpoint, to deficiencies which might be identified by PSRO review.

"We support the statewide PSRO concept for another major reason—it represents the best vehicle, in a state the size of West Virginia, to assure on a consistent basis an adequate resource of high-quality and diversified review capability. There are relatively small numbers of physicians in West Virginia in some of the key specialties. State Medical Licensing Board compilations, for example, show only five thoracic surgeons; 15 dermatologists; 12 neurological surgeons; five classified as specialists in the cardiovascular and pulmonary disease areas. In addition, distribution of those in a number of other specialties, such as urology, anesthesiology and even in internal medicine, is uneven to a degree that well-staffed review panels are not possible in many individual parts or sections of the state.

"A word seems in order at this point about the geopraphy of West Virginia. Historically, the state's physical make-up has led to isolation of some sec-

Visiting during a reception at the State Medical Association's Annual Meeting (in left photo) are, from left, Drs. Frank J. Holroyd of Princeton, H. Thomas McGuire, New Castle, Delaware; and William A. Sodeman, Philadelphia. In the center photo, Dr. Tracy N. Spencer, Jr., of South Charleston (left) chats during a coffee break with Dr. J. Dennis Kugel, Charleston. Shown at the right, during a reception, are, from left, Drs. W. J. (Jack) Lewis of Dayton, Ohio, Chairman of the Board of Directors, American Medical Political Action Committee; Dr. Russell B. Roth, Erie, Pennsylvania, AMA President; and William L. Watson, Chicago, Executive Director, AMPAC.

tions from others; to varying economic, educational and other standards—and sometimes to downright provincialism. However, with a vastly improved and expanding highway network, along with other modern advances in communications capabilities, these geographical features no longer constitute significant barriers or matters of particular concern. Furthermore, in the PSRO structure as proposed in this statement, geography is not a major element. The actual operating mechanisms for review must, by law, be locally based to the most feasible and practical degree.

"There are still other significant reasons behind our support for a statewide PSRO. Basic implementation of the system would not only be simpler, but data collection which must become a vital element in the whole program can be greatly simplified. This can result from the particular ease with which coordination can be effected with generally centralized Medicare and Medicaid fiscal agents. Development of criteria and standards of care can be facilitated by bringing to bear the combined resources a statewide PSRO can provide. Further refinements, adjustments and other program changes—in response to Department of Health, Education and Welfare rules and regulations; future legislation, or problems that develop within the system, itself — can be brought about much more quickly and effectively. Time, money and significant effort—particularly as such effort involves the busy practicing physician—all can be saved by assuring against duplication in administrative and support mechanisms. Duplication is costly, in the final analysis, to the taxpayer—and it is the taxpayer who is supposed to reap major new benefits in high-quality, economical medical care from effective PSRO activity.

"In summary, the West Virginia State Medical Association accepts the PSRO challenge. West Virginia physicians, however, are the only persons who can make the system work. They, and they alone, can provide high-quality medical care envisioned by the PSRO concept. They, alone, can assure the professional, medical and operational responsibility for review, with appropriate public accountability, that Senator Bennett and other members of the Congress have called for.

"Accordingly, West Virginia physicians want the opportunity to undertake the PSRO responsibility along the lines they feel are most practical—specifically through a statewide PSRO structure providing the overall review and other capabilities to assure that the law can be effectively and properly implemented. It must be reiterated that this structure will retain the heaviest possible emphasis on mechanisms for actual review by participating physicians at local levels—but at the same time it offers the most effective means of assuring consistently balanced and high-quality review because of the total resources it represents.

"A statewide PSRO—in West Virginia—offers the most economical approach to this new challenge, and the most efficient and effective way of assuring proper data collection, administrative and other vital support services.

"It provides the strongest and best continuing medical education vehicle in relation to PSRO activities. It assures an ongoing means of monitoring all review activities, and prompt steps to effect desirable or necessary improvements. It offers an effective structure for the development of criteria and standards of care, and a consistency in such standards, through its own resources and others available to it.

"Equally important, this is the approach the physicians, themselves, have indicated that they prefer. In their view, this is the approach which will give them the best opportunity to do the job that rests finally and squarely in their hands.

"Thank you."

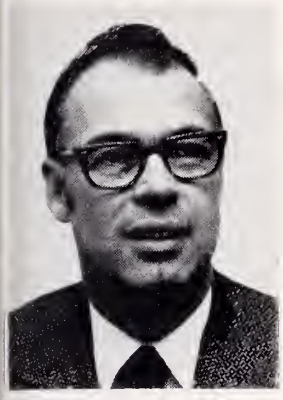
1974 Meeting at The Greenbrier

The Council decided, at its pre-convention session, to hold the West Virginia State Medical Association's 1974 Annual Meeting at The Greenbrier in White Sulphur Springs. The meeting, the Association's 107th, will be held August 21-24.

Enjoying themselves at a reception during the Annual Meeting are, in the left photo, from left, Dr. and Mrs. Kenneth G. MacDonald of Charleston; Dr. James H. Gosman, President of the Indiana State Medical Association; and James A. Waggener, Executive Secretary of the Indiana State Medical Association. At the right, a group socializes prior to a luncheon honoring Past Presidents of the West Virginia State Medical Association.

WVU Names Dr. Traubert Chairman, Department Of Family Practice

The appointment of Dr. John W. Traubert of Wellsburg as Chairman of the Department of Family Practice, West Virginia University School of Medicine, was announced recently by WVU President James G. Harlow.



John W. Traubert, M. D.

Born in Wheeling, Doctor Traubert received his A.B. degree from WVU in 1956. He received both his M.S. degree in physiological chemistry and his M.D. degree from Ohio State University during which time he held National Institutes of Health Research fellowships in endocrinology and in pediatric clinical toxicology. He also served as an Instructor in Pharmacology and Biochemistry while at OSU.

His internship and family practice residency were served at Mt. Carmel Hospital in Columbus, Ohio.

"As a native and family physician of West Virginia, Doctor Traubert knows the problems and needs of our state first hand," said Dr. John E. Jones, Acting Dean of the WVU School of Medicine. "He has spent a great deal of time thinking about what type of primary medical care this state needs."

"He has past academic experience, significant clinical practice experience and is well trained. He is current in his thinking and his medical information level is high. He has all the qualities we require in a physician-teacher."

As a Professor of Medicine and clinician, Doctor Jones has been closely associated with Doctor Traubert for more than four years through postgraduate seminars and referrals of patients to University Hospital.

"His referral information has been outstanding," Doctor Jones added. "The quality of care which his patients received, his compassion and his dedication are evident."

Doctor Traubert, who is current Vice President of the West Virginia Chapter, American Academy of Family Physicians, is both a charter Fellow of the national organization and a charter Diplomate of its board. He also served on the medical education committee of the West Virginia Academy and the West Virginia State Medical Association. He also is a member of the American Medical Association, the American Association of Physicians and Surgeons and the International Association of Coroners and Medical Examiners.

In 1969 and again last year, Doctor Traubert received an American Medical Association Physicians Recognition Award. He also was a recipient of a Mead-Johnson Award in General Practice in 1966-67.

Doctor Traubert is President of the Brooke County Medical Society and serves as health commissioner and coroner in that county.

He is a member of the staff of Wheeling Hospital, where he served as Chairman of the Family Practice section, and Ohio Valley General Hospital.

Doctor Traubert is married to the former Nancy Bigler, a registered nurse. The couple has four children.

Dr. Clark K. Sleeth, Professor of Medicine and former Dean of the School of Medicine, has served as Acting Chairman of the Department of Family Practice since early this year. He has been instrumental in laying the groundwork for the program and its clinic.

The Family Practice Program will stress five main areas of primary medical care: Treatment principally on an outpatient basis; treatment of the family unit through its individual members; health maintenance in addition to episodic crisis care; research and evaluation of methods of health delivery; continuing education as required by the American Board of Family Practice to achieve and maintain certification.

The clinic, unlike most others at the Medical Center, will provide primary care and not require referral. Families accepted as patients will be representative of regional population with the proportionate numbers determined on the basis of age, sex, race and socio-economic status.

Residency training will require three years past the M.D. degree. The first four residents in the WVU program will begin training in July 1974.

Once fully established, the program must be accredited by the American Medical Association and the Board of Family Practice. Those completing the residency will then be eligible to take examinations for board certification.

Mrs. M. Bruce Martin, left, of Huntington and Mrs. Robert G. Janes of Fairmont display an "Award of Merit" presented at the Convention of the Woman's Auxiliary to the American Medical Association which was held this past summer in New York City. Presented by the Education and Research Foundation of the AMA, the Award recognized the Woman's Auxiliary to the West Virginia State Medical Association for contributions to AMA-ERF representing more than $10 per capita membership. Mrs. Janes attended the convention as the State Auxiliary's President, while Mrs. Martin was the immediate Past President.

Mrs. J. Dennis Kugel Installed As Auxiliary President

Mrs. J. Dennis Kugel of Charleston assumed the Presidency of the Woman's Auxiliary to the West Virginia State Medical Association at the group's 49th Annual Meeting at The Greenbrier in White Sulphur Springs August 22-25.

Mrs. J. Dennis Kugel

Mrs. Kugel, who was installed by Mrs. Willard C. Scrivner, President of the Woman's Auxiliary to the American Medical Association, sees membership as the leading goal of the State Auxiliary this year. "My big push this year will be membership—to retain those we have, retrieve many we've lost, and recruit new members."

The wife of a radiologist and mother of three children, Mrs. Kugel succeeded Mrs. Robert G. Janes of Fairmont. The Auxiliary elected Mrs. William T. Lawson of Fairmont as President Elect, and the following additional officers:

Mrs. James H. Walker of Charleston, Vice President; Mrs. Claude S. Lawson, Jr., Fairmont, Recording Secretary; Mrs. W. Paul Elkin, Charleston, Corresponding Secretary; Mrs. J. L. Mangus, Charleston, reelected Treasurer, and Mrs. Janes, Parliamentarian.

Mrs. John D. H. Wilson, Clarksburg, Northern Regional Director; Mrs. D. Sheffer Clark, Huntington, Western Regional Director; Mrs. E. G. Friera, Romney, Eastern Regional Director, and Mrs. John J. Bryan, Bluefield, Southern Regional Director.

Committee Appointments

Mrs. Kugel also announced these appointments of Committee Chairmen:

Mrs. Robert R. Weiler, Wheeling, AMA Education and Research Foundation; Mrs. Pat A. Tuckwiller, Charleston, Archives and History; Mrs. M. Bruce Martin, Huntington, By-Laws and Handbook; Mrs. O. M. Harper, Clendenin and Mrs. A. G. Capinpin, Charleston, Convention; Mrs. T. Keith Edwards, Bluefield, Editor, State News Bulletin; Mrs. P. R. Ferraraccio, Bluefield, Circulation Manager; Mrs. Charles E. Andrews, Morgantown, Finance; Mrs. Claude S. Lawson, Fairmont; Mrs. Charles S. Harrison, Clarksburg; and Mrs. J. T. Mallamo, Fairmont, Health Careers Fund.

Mrs. Louis N. Groves, Richwood, Health Education; Mrs. Paul Francke, Jr., Charleston, Health Services; Mrs. Bernard Zimmermann, Morgantown, Health Manpower; Mrs. Roland S. Birckhead, Gauley Bridge, International Health; Mrs. J. E. Blaydes, Jr., Bluefield, Legislation; Mrs. J. N. Jarrett, Oak Hill, *md's wife;* and Mrs. I. Braxton Anderson, Beckley, Mental Health.

Mrs. Claude R. Davisson, Weston, Necrology and Chaplain; Mrs. John E. McKenzie, Beckley, Press and Publicity; Mrs. Julius L. Berkley, Charleston, Southern Medical Councilor, and Mrs. George A. Curry, Morgantown, Woman's Auxiliary to the Student American Medical Association.

Prevention of Child Abuse

"Our national concern," Mrs. Kugel stated, "is preventing child abuse. Our State Auxiliary will study this project to see what we can do within the State."

Mrs. Kugel said another interest of the Auxiliary is GEMS — Good Emergency Mother Substitutes. "We would like to see a home in every block where children in that block know they can go for help in case of emergency."

The Kugels' daughter, Mrs. Julie Nickelsen, is doing her residency in family practice in Buffalo, New York, while her husband, James, does his residency in pediatrics. Their eldest child, Jeffrey, is working on his Ph. D. in biology at Florida State and plans to enter medical school. Their youngest child, Tom, is in pre-med at Michigan State.

Mrs. Kugel, a native of New Jersey, grew up in Norristown, Pennsylvania and was graduated from the Montgomery Hospital School of Nursing in that city.

The new Auxiliary President is a Past President of the Auxiliary to the Kanawha Medical Society and has been on the State Auxiliary Board for 10 years. In Charleston, she served four years on the United Fund Budget panel, and belongs to Woman Builders of Morris Harvey College and the Thomas Memorial Hospital Auxiliary.

Medical Institute Chartered As Educational Vehicle

After several years of study and development, a new non-profit, non-stock medical corporation with a deep-rooted educational base is assuming definite form in West Virginia.

Articles of Incorporation for the West Virginia Medical Institute, Inc., now have been filed with the Secretary of State, and the charter has been issued. By-Laws also have been put into final form.

Development of the corporation has stemmed from recognition, particularly within the State Medical Association leadership, that a separate operating vehicle can best serve as a "home" for scientific, educational and related activities.

Enactment by Congress late in 1972 of the Professional Standards Review Organization (PSRO) legislation as a part of voluminous Social Security Act Amendments gave further impetus to development of the new organization.

Open to all licensed, practicing doctors of medicine and osteopathy in West Virginia on a voluntary membership basis, the West Virginia Medical Institute, Inc., now is viewed as a structure which will be eligible to enter into possible contracts with proper Federal officials in implementation of the PSRO law.

For further information on PSRO developments in West Virginia, please see a related story dealing primarly with upcoming designations of review areas on page 300 of this issue of *The Journal.*

In line with extended planning, incorporators of the new organization were officers of the State Medical Association, but the charter membership will include a broader base upon which the permanent leadership and operations can be developed in a form wholly independent and free-standing.

Potential educational components of the Institute will include the future design the Voluntary Office Self-Audit Service (VOSAS) experimental program in continuing medical education might assume, particularly in the light of educational needs PRSO might bring.

Appropriately, the key steps in continued development, and actual establishment of the Institute was centered in action taken by the House of Delegates at the Association's Annual Meeting in August at The Greenbrier.

Support for such development and implementation—and for a Medical Association position expressed earlier relative to designation of West Virginia as a single PSRO area—came in the following resolution adopted without a dissenting vote by the House:

Whereas, The House of Delegates at its August 26, 1972, session during the West Virginia State Medical Association's 105th Annual Meeting, authorized the Council to proceed with formation of a medical foundation, subject to the approval of local component medical societies; and

Whereas, approval has been expressed by all local societies making formal comments on drafts of Articles of Incorporation and By-Laws submitted to them for a foundation open to membership, on a voluntary basis, to all physicians licensed to practice in West Virginia; and

Whereas, Articles of Incorporation and By-Laws now are in the form necessary to proceed with actual and formal establishment of a foundation under the corporate name of West Virginia Medical Institute, Inc.,; and

Whereas, Congress enacted late in 1972 new Professional Standards Review Organizations (PSRO) legislation related to the quality, necessity and appropriateness of hospital and other institutional care for Medicare, Medicaid and Maternal and Child Health Program patients,

Therefore, be it resolved, That the West Virginia State Medical Association further reaffirm in the most positive and firm manner its position calling for designation of the State of West Virginia as a PSRO area; and

Be it further resolved, That the West Virginia State Medical Association support the continued development and implementation of the West Virginia Medical Institute, Inc., as an independently incorporated, non-stock, non-profit corporation to contract with the U. S. Department of Health, Education and Welfare to carry out PSRO activities in West Virginia; and to operate related educational and other programs within the scope of its authority.

Dr. Bateman Elected Member Of Institute Of Medicine

Mildred Mitchell Bateman, M. D., Director of the West Virginia Department of Mental Health, has been elected to membership in the Institute of Medicine of the National Academy of Sciences.

Mildred M. Bateman, M.D.

New members are elected by current active members for their significant contribution to health and medicine, or to such related fields as the social and behavioral sciences, law, administration and engineering.

Doctor Bateman is one of 60 new members, including 35 M.D.'s, recently elected to the Institute, raising its total membership to 211 active and five senior members. The Institute's charter calls for an eventual active membership of not more than 400. One fourth of the members must be from professions other than health and medicine.

Standing and Special Committees Appointed by Doctor McCoy

The following standing and special committees have been named by Dr. A. Thomas McCoy of Charleston, President of the West Virginia State Medical Association, to function during his one-year term of office:

Aging

Eldon B. Tucker, Morgantown, Chairman; Myer Bogarad, Weirton; and Richard Hamilton, St. Marys.

Cancer

Alvin L. Watne, Morgantown, Chairman; John J. Battaglino, Jr., Wheeling; F. Lloyd Blair, Parkersburg; Harry F. Cooper, Beckley; L. Walter Fix, Martinsburg; William E. Gilmore, Parkersburg; David B. Gray, Charleston; Ray A. Harron, Bridgeport; Hu C. Myers, Philippi; Jess S. Renedo, Wheeling; Richard G. Starr, Beckley; Charles W. Thacker, Parkersburg; John W. Trenton, Kingwood; James H. Walker, Charleston; and Chauncey B. Wright, Huntington.

Constitution and By-Laws

Harry S. Weeks, Jr., Wheeling, Chairman; George R. Callender, Jr., Charleston; Richard E. Flood, Weirton; J. C. Huffman, Buckhannon; Carl B. Hall, Charleston; Sobisca S. Hall, Clarksburg; John W. Hash, Charleston; James S. Klumpp, Huntington; Athey R. Lutz, Parkersburg; Richard V. Lynch, Jr., Morgantown; and L. J. Pace, Princeton.

Insurance

C. A. Hoffman, Huntington, Chairman; Andrew J. Barger, Glen Dale; James A. Barnes, Beckley; Robert L. Chamberlain, Buckhannon; John T. Chambers, Charleston; R. U. Drinkard, Wheeling; A. C. Esposito, Huntington; F. Perry Greene, Jr., Parkersburg; Upshur Higginbotham, Bluefield; Kenneth G. MacDonald, Charleston; Buford W. McNeer, Hinton; J. C. Pickett, Morgantown; Robert S. Robbins, Wheeling; and C. Vincent Townsend, Martinsburg.

Interprofessional Relations

William E. Gilmore, Parkersburg, Chairman.

Sub-Committees

Medico-Legal: A. J. Villani, Welch, Chairman; S. William Goff, Parkersburg; George V. Hamrick and Paul H. Revercomb, Charleston.

Medicine and Religion: Tracy N. Spencer, Jr., South Charleston, Chairman; Dwight P. Cruikshank, Parkersburg; and V. L. Dyer, Petersburg.

Medicine and Pharmacy: R. C. Cowan, Jr., Parkersburg, Chairman; John L. Fullmer, Morgantown; and L. Dale Simmons, Clarksburg.

Medical-Dental Liaison: George L. Armbrecht, Wheeling, Chairman; Alberto G. Capinpin, Charleston; and James A. Thompson, Clarksburg.

Nurses Liaison: Richard E. Flood, Weirton, Chairman; Jean P. Cavender, Charleston; John J. Mahood, Bluefield; and L. J. Pace, Princeton.

Legislative

Frank J. Holroyd, Princeton, Chairman; W. P. Bittinger, Oak Hill; J. E. Blaydes, Jr., Bluefield; John T. Chambers, Charleston; George A. Curry, Morgantown; Del Roy R. Davis, Kingwood; Roy A. Edwards, Jr., and A. C. Esposito, Huntington; George Gevas, Parkersburg; Paul E. Gordon, Clarksburg; Louis W. Groves, Jr., Richwood; N. B. Groves, Jr., Martinsburg; Carl B. Hall, John M. Hartman, John W. Hash and John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; Jack Leckie, Huntington; Charles L. Leonard, Elkins; Milton J. Lilly, Jr., Charleston; Paul L. McCuskey, Parkersburg; Charles W. Merritt, Beckley; Thomas G. Reed, Charleston; Joseph D. Romino, Fairmont; Carl J. Roncaglione, William B. Rossman, and Page H. Seekford, Charleston; Robert G. Shirey, Lewisburg; Jack J. Stark, Belpre, Ohio; I. Ewen Taylor, Huntington; A. J. Villani, Welch; David E. Wallace, Madison; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; J. Hugh Wiley, Morgantown; and David E. Yoho, Glen Dale.

Maternal and Perinatal Fetal Welfare

A. J. Villani, Welch, Chairman; Walter A. Bonney, Jr., Morgantown; Clarence H. Boso and Thomas J. Conaty, Huntington; Robert D. Crooks, Parkersburg; Larry D. Curnutte and Frederick H. Dobbs, Charleston; T. Keith Edwards, Bluefield; Thomas G. Folsom, Huntington; N. W. Fugo, Morgantown; George Gevas, Parkersburg; Robert Greco, Morgantown; George L. Grubb, Charleston; C. S. Harrison, Clarksburg; Edwin J. Humphrey, III, Huntington; W. Gene Klingberg, Morgantown; A. Robert Marks, Clarksburg; Rose H. McClanahan, Charleston; Charles W. Merritt, Beckley; Thomas G. Potterfield, Charleston; Robert P. Pulliam, Beckley; Meryleen B. Smith, Peterstown; Gates J. Wayburn, Huntington; and Patrick C. Williams, Jr., Charleston.

Medical Aspects of Sports

Richard W. Corbitt, Parkersburg, Chairman; K. D. Bowers, Jr., Morgantown; R. L. Chamberlain, Buckhannon; Robert A. Crawford, Jr., and Henry R Glass, Jr., Charleston; Robert W. Howes, Jr., Parkersburg; Joe N. Jarrett, Oak Hill; James S. Kessel, Ripley; Jack C. Morgan, Fairmont; George Naymick, Weirton; W. H. Rardin, Beckley; Carl J. Roncaglione, Charleston; George W. Rose, Clarksburg; Herbert E. Warden, Morgantown; and Moseley H. Winkler, Charleston.

Medical Economics

Carl J. Roncaglione, Charleston, Chairman; and W. Alva Deardorff, Charleston, Vice Chairman.

Sub-Committees

Federal Medical Activities: J. L. Mangus, Charleston, Chairman; George R. Callender, Jr., Charleston; Daniel Hale, Princeton; Richard V. Lynch, Jr., Morgantown; James T. Spencer and James H. Walker, Charleston.

State Workmen's Compensation: Lawrence S. Miller, Morgantown, Chairman; Marshall J. Carper, Jacques Charbonniez and W. Alva Deardorff, Charleston; Daniel W. Dickinson, Wheeling; A. C. Esposito, Huntington; Robert L. Ghiz, Charleston;

Thomas J. Holbrook, Huntington; Ralph J. Holloway, South Charleston; James T. Hughes, Ripley; Theodore P. Mantz and William C. Morgan, Jr., Charleston; James E. Powers, Princeton; Clifford A. Stevenson, Beckley; and James H. Walker, Charleston.

Blue Cross-Blue Shield Third Party: Milton J. Lilly, Jr., Charleston, Chairman; Charles E. Andrews, Morgantown; Robert W. Bess, Jr., Piedmont; Donald R. Chadwick, Beckley; C. A. Hoffman, Huntington; George W. Hogshead, Nitro; Logan W. Hovis, Vienna; Ray M. Kessel, Logan; Milton E. Nugent, Wheeling; and J. D. H. Wilson, Clarksburg.

Public Welfare—Joint Conference Committee: Thomas P. Long, Man, Chairman; George R. Callender, Jr., Charleston; C. Richard Daniel, Beckley; Richard E. Flood, Weirton; N. B. Groves, Martinsburg; John M. Hartman, Charleston; W. Gene Klingberg, Morgantown; Seigle W. Parks, Charleston; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; Wm. D. McMillan, Jr., Charleston, and Richard V. Lynch, Jr., Morgantown, Vice-Chairmen; Charles E. Andrews, Morgantown; Leo H. T. Bernstein, Martinsburg; William H. Carter, Charleston; Del Roy R. Davis, Kingwood; C. Richard Daniel, Beckley; Thomas O. Dotson, White Sulphur Springs; Albert C. Esposito, Huntington; William E. Gilmore, Parkersburg; Robert D. Hess, Bridgeport; Upshur Higginbotham, Bluefield; Winfield C. John, Huntington; George M. Kellas, Wheeling; Jack Leckie, Huntington; Mary Lou L. Lewis, Charleston; John D. Lindsay, Jr., Fairmont; David Z. Morgan, Morgantown; Milan J. Packovich, Weirton; Robert R. Pittman, Martinsburg; Herbert H. Pomerance, Charleston; Joseph B. Reed, Buckhannon; Thomas G. Reed, Charleston; Howard B. Sauder, Wheeling; Harold Selinger and Edwin M. Shepherd, Charleston; Philip M. Sprinkle, Morgantown; Richard G. Starr, Beckley; Hartwell G. Thompson, Charleston; John W. Traubert, Wellsburg; and J. Hugh Wiley, Morgantown.

Medical Scholarships

Martha Jane Coyner, Harrisville, Chairman; Marshall J. Carper, Charleston; Robert D. Hess, Bridgeport; Thomas J. Holbrook, Huntington; Russel Kessel, Charleston; John Mark Moore, Wheeling; and Clark K. Sleeth, Morgantown.

Medical Emergencies and Civil Defense

John A. B. Holt, Charleston, Chairman; Harold D. Almond, Buckhannon; Dominic A. Brancazio, Weirton; Harry F. Coffman, Keyser; Salvador Diaz, Huntington; Ernest G. Guy, Philippi; Charles H. Hiles, Wheeling; John J. Mahood, Bluefield; Donald R. Lantz, Parkersburg; Joseph T. Mallamo, Fairmont; John B. Markey, Charleston; James G. Ralston, Clarksburg; William S. Sadler, Barboursville; Lyle D. Vincent, Parkersburg; John W. Whitlock, Beckley; and E. Andrew Zepp, Martinsburg.

Mental Health

Roy A. Edwards, Jr., Huntington, Chairman; Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; William B. Rossman, Charleston; O. Lee Trick, Morgantown; A. L. Wanner and Stephen D. Ward, Wheeling; Charles C. Weise, Charleston; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Jr., Charleston; Robert D. Hess, Bridgeport; and Logan W. Hovis, Vienna.

Program

J. Hugh Wiley, Morgantown, Chairman; John T. Chambers, Charleston; William E. Gilmore, Parkersburg; Winfield C. John, Huntington; Ray M. Kessel, Logan; and Philip M. Sprinkle, Morgantown.

Public Service

Albert C. Esposito, Huntington, Chairman; John M. Bobbitt, Huntington; George A. Curry, Morgantown; C. R. Davisson, Weston; Leonard M. Eckmann, South Charleston; G. Thomas Evans, Fairmont; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; C. A. Logue, Morgantown; George E. McCarty, Parkersburg; Charles W. Merritt, Beckley; L. J. Pace, Princeton; Joseph B. Reed, Buckhannon; Page H. Seekford, Charleston; Jack J. Stark, Belpre, Ohio; Stephen D. Ward, Wheeling; and A. J. Weaver, Clarksburg.

Resolutions

Richard E. Flood, Weirton, Chairman; George R. Callender, Jr., Charleston; C. A. Hoffman, Huntington; Worthy W. McKinney, Beckley; L. J. Pace, Princeton; and Harry S. Weeks, Jr., Wheeling.

Rehabilitation

Buford W. McNeer, Hinton, Chairman; Jean P. Cavender, Charleston; James A. Gardner, Beckley; James A. Heckman, Huntington; Thomas M. Howes, Morgantown; Francis H. Hughes, Parkersburg; Ralph H. Nestmann, Charleston; J. C. Pickett, Morgantown; Jack Pushkin, Charleston; M. D. Reiter, Wheeling; L. Dale Simmons, Clarksburg; Robert R. Weiler, Wheeling; J. Hugh Wiley, Morgantown; and Roy James Yates, Beckley.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Harold D. Almond, Buckhannon; J. C. Arnett, Rowlesburg; Ralph H. Boone, Sistersville; B. S. Brake, Clarksburg; Robert W. Coplin, Elizabeth; Del Roy R. Davis, Kingwood; N. H. Dyer, Charleston; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; Robert R. Frye, Mannington; O. M. Harper, Clendenin; Mehmet V. Kalaycioglu, Shinnston; Charles T. Lively, Weston; Ralph McGraw, Follansbee; Joseph B. Reed, Buckhannon; Charles J. Sites, Franklin; and Charles E. Staats, Charleston.

Tuberculosis

Hugh S. Edwards, Beckley, Chairman; J. N. Aceto, Wheeling; Charles E. Andrews, Morgantown; Robert M. Biddle, Parkersburg; J. M. Brand, Chester; William L. Cooke, Charleston; N. Allen Dyer, Bluefield; George F. Evans, Clarksburg; Dominic J. Gaziano, Charleston; G. R. Maxwell, Morgantown; Ralph H. Nestmann and Morris H. O'Dell, Charleston; Robert J. Reed, III, Wheeling; James T. Smith, Charleston; M. A. Viggiano, New Martinsville; James H. Walker, Charleston; and David H. Williams, Weirton.

Venereal Disease

N. H. Dyer, Charleston, Chairman; Hunter Boggs, Charleston; C. Y. Moser, Kingwood; Frank M. Peck, Huntington; David S. Pugh, Chester; Thomas L. Thomas, Wheeling; M. A. Viggiano, New Martinsville; Lyle D. Vincent, Parkersburg; and Isaiah A. Wiles, Morgantown.

SPECIAL COMMITTEES

AMA-ERF

J. Keith Pickens, Clarksburg, Chairman; Irwin M. Bogarad, Weirton; Harry F. Cooper, Beckley; John E. Echols, Richwood; John H. Gile, Parkersburg; Joseph Gilman, Clarksburg; Daniel Hale, Princeton; Robert W. Howes, Jr., Parkersburg; Joe N. Jarrett, Oak Hill; Buford W. McNeer, Hinton; David Z. Morgan, Morgantown; Jack C. Morgan, Fairmont; Earl S. Phillips, Wheeling; Donald R. Roberts, Elkins; George A. Shawkey, Charleston; Wilson P. Smith, Huntington; John W. Trenton, Kingwood; Lysle T. Veach, Petersburg; and E. Andrew Zepp, Martinsburg.

School Health

Peter A. Haley, Charleston, Chairman; R. J. Bailey, Parkersburg; J. M. Brand, Chester; Hugh M. Brown, Clarksburg; Thomas G. Folsom, Huntington; Grover C. Hedrick, Jr., Beckley; Robert G. Janes, Fairmont; Edward Shupala, Parkersburg; Paul C. Soulsby, St. Albans; Thomas L. Thomas, Wheeling; and Eli J. Weller, Weirton.

WVU Liaison

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Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Oct. 1-4—AAFP, Denver.
Oct. 6-11—Indiana St. Med. Assn., Indianapolis.
Oct. 7-11—Am. Soc. Anesth., San Francisco.
Oct. 10-13—Pa. Med. Society (Scientific), Harrisburg.
Oct. 15-19—ACS Clinical, Chicago.
Oct. 17-21—Eastern Orthopaedic Assn., White Sulphur Springs.
Oct. 18-21—Med. Soc. of Va., Norfolk.
Oct. 18-21—Amer. Acad. of Child Psych., Washington.
Oct. 20-25—Amer. Acad. of Ped., Chicago.
Oct. 21-23—W. Va. Hospital Assn., White Sulphur Springs.
Oct. 21-26—Am. Acad. Physical Med. & Rehab., Washington.
Oct. 22-24—Am. Coll. of Gastro., L. A.
Oct. 26-28—Pot.-Shen. PG Institute, Martinsburg.
Oct. 31—Nov. 1—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 4-8—Assn. Am. Med. Colleges, Wash.
Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-9—Am. Cancer Society, New York.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-12—Am. Assn. Cancer Educat., Honolulu.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.
Nov. 14-17—Am. Acad. of Neuro. Surgery, Pasadena.

Dec. 1-4—Am. Soc. Hematology, Chicago.
Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.
Dec. 3-5—So. Surg. Assn., Hot Springs, Va.

1974

Jan. 6-8—Soc. of Gyn. Oncol., Key Biscayne, Fla.
Jan. 18-20—Mid-Winter Clinical Conf., Charleston.
Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.
Jan. 19-24—Am. Acad. Ortho. Surgeons, Dallas.
Jan. 25-27—So. Rad. Conf., Point Clear, Ala.
Jan. 25-27—AMA Natl. Leadership Conf., Chicago.
Feb. 10-16—Am. Soc. of Contemp. Ophthal., Miami Beach.
Feb. 10-16—Am. Soc. of Contemp. Med. & Surg., Miami Beach.
Feb. 11-14—Am. Coll. Card., N. Y.
Feb. 14-16—Soc. Univ. Surgeons, St. Louis.
Mar. 15-17—AMA-AMPAC Pub. Affairs Workshop Washington, D. C.
Mar. 31—April 5—Am. Coll. Physicians, N. Y.
April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.
April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.
April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.
April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.
May 17-18—Am. Assn. Clin. Urologists, St. Louis.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.
Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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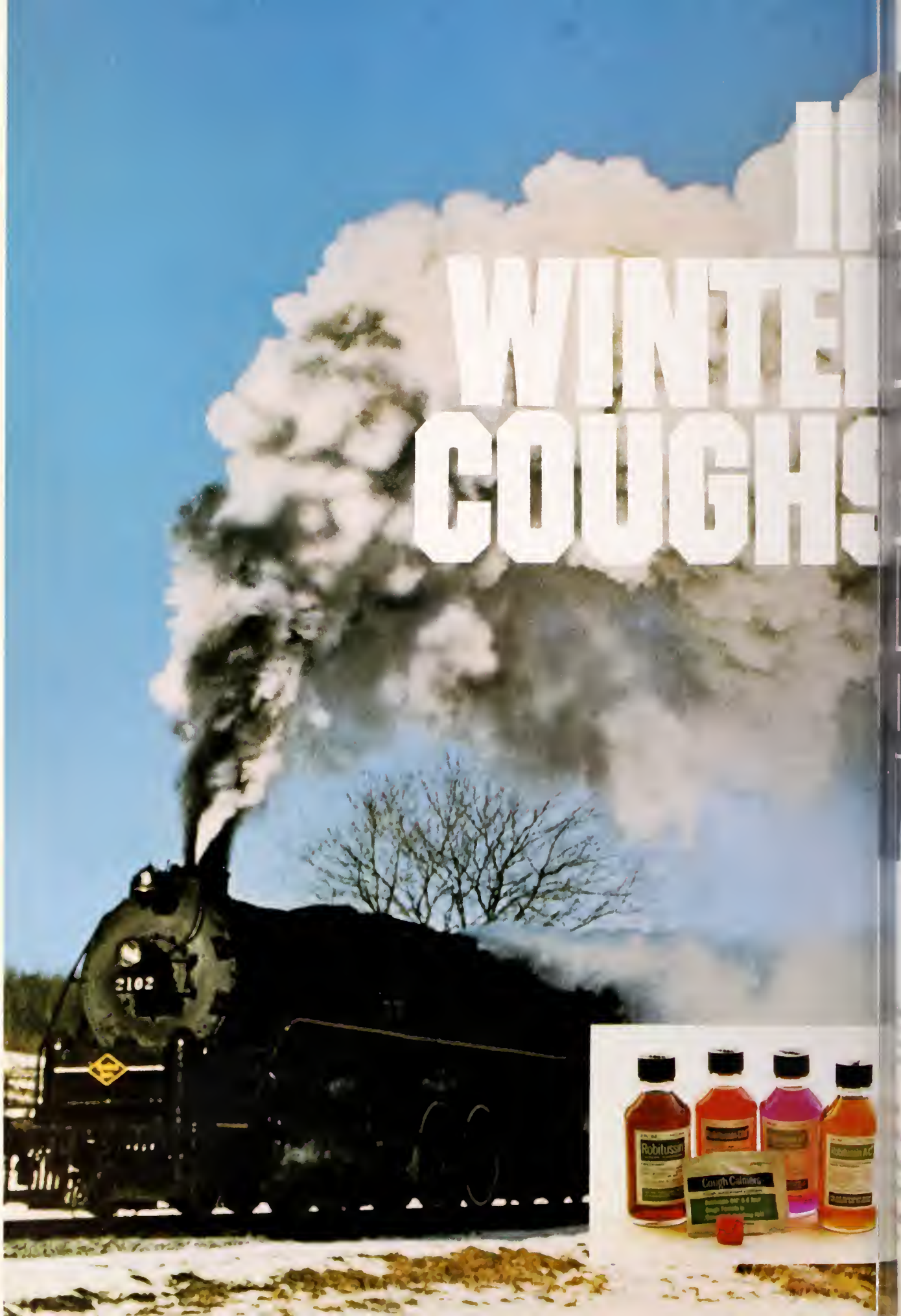
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WVU Medical Center
–News–

• Compiled from moteriol furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

EXPERIENCE with the cancer drug adriamycin at West Virginia University Medical Center parallels findings reflected in a statement made recently by Dr. Frank J. Rauscher, Jr., Director of the National Cancer Institute (NCI) in Bethesda, Maryland.

Speaking at a Senate Appropriations Committee hearing, where he announced the designation of eight medical institutions as comprehensive regional cancer centers, Doctor Rauscher reported that "the emerging story of adriamycin" was one of the most encouraging findings of the past year. He cited a study, involving 1,000 patients, in which the drug was shown to act against breast cancer, lung cancer, sarcomas, lymphomas and other cancers.

Since January, Dr. Raymond B. Weiss, WVU Medical Center's onocologist, has supervised the administration of adriamycin to about 30 selected cancer patients ranging in age from 16 to the late 60's. He reports tumor regression in one-fourth to one-third of these patients—an achievement considering the less than five per cent regression rate accomplished in some of the same type cancers by other treatments.

Doctor Weiss is especially happy with the drug's destructive effect on advanced muscle and bone tumors on which little other treatment has ever proved helpful.

Adriamycin, which is really a toxic antibiotic, is an extract of a species of fungus, and was discovered in 1968 by scientists working for a drug company in Milan, Italy. Experiments abroad and for the past three years in the United States showed it to be the most promising new chemotherapeutic agent against cancer, although several more years of study must elapse before its full scope is known.

Controlled and distributed in the U. S. only by the NCI, adriamycin currently is in the stage of clinical trial process (establishing its activity.)

In his studies at WVU Medical Center, Doctor Weiss keeps to a protocol, maintains detailed records and makes reports regularly to the NCI.

Patients he treats with adriamycin usually receive it over a three-day period every three weeks. Doctor Weiss administers the initial doses, after which they can be given by a patient's family physician (a factor that enables many doctors to play a part in some of the most advanced cancer work now being done).

Because the drug's great toxicity can have side effects involving the bone marrow and heart (loss of hair is almost routine while on therapy), and because dosages may need adjustment, patients return to University Hospital every three weeks for evaluation by Doctor Weiss.

Dr. Barbara Jones, pediatric onocologist at the Medical Center, also is using the drug in selected children with advanced cancers.

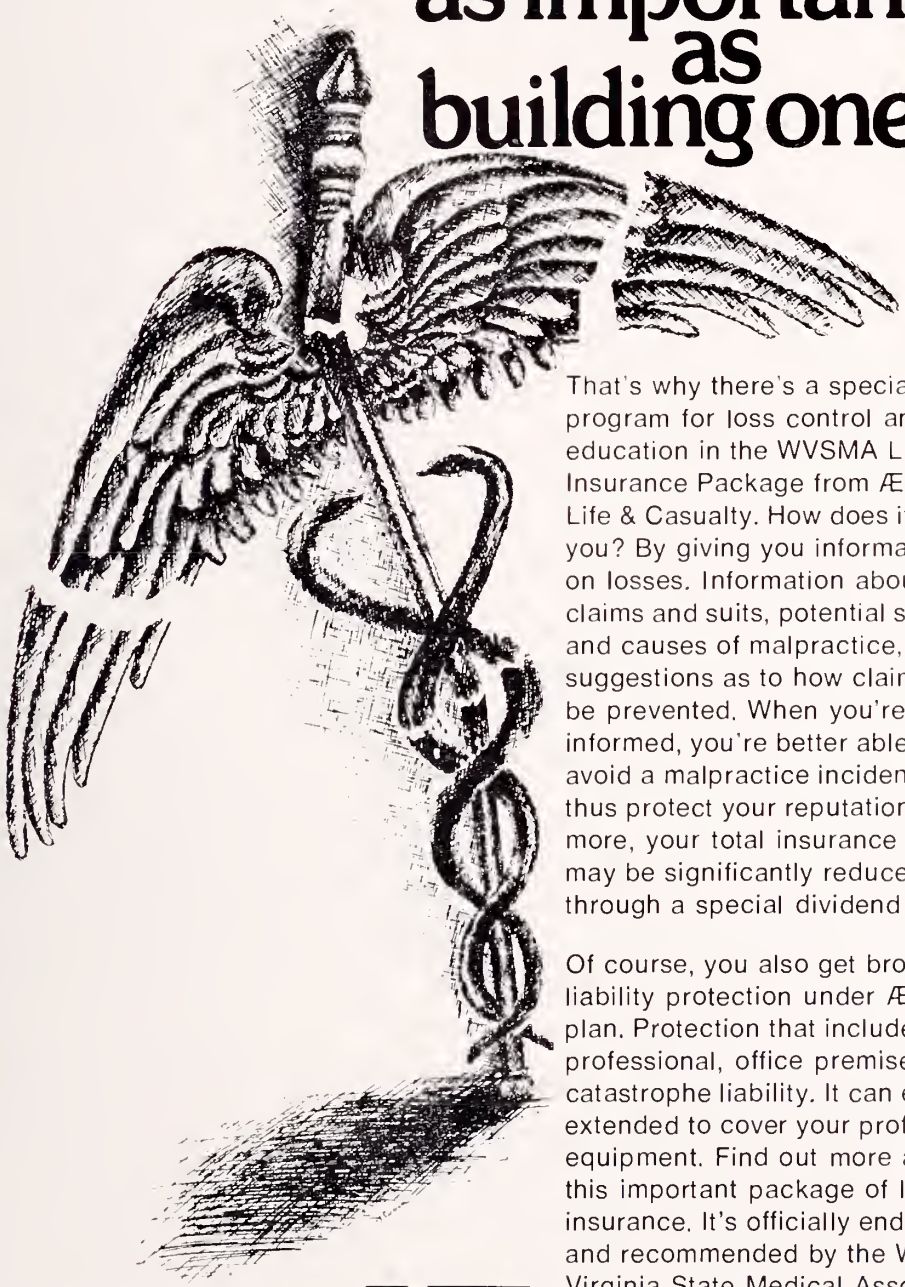
Student Completes Summer Research

Paul Nefflen of Elkins recently completed a summer research program in dermatology at West Virginia University Medical Center. Nefflen was one of 10 medical students in the United States who received a National Program for Dermatology fellowship for $1,000 presented by Syntex Laboratories.

Under the supervision of Dr. Morton Friedman, Associate Professor of Anatomy, and Dr. William Welton, Professor and Chairman of Dermatology, Nefflen examined a variety of human skin cancers with the electron microscope. His project expanded previous electron microscopic studies of benign and malignant tumors made by Drs. Friedman and Welton.

Dr. Lester A. Reid (center) conducts a pulmonary function test at West Virginia University Medical Center as Dr. David M. Murphy (left), Assistant Professor of Medicine; Mrs. Velma W. Miller and Dr. W. Keith C. Morgan (at right), Professor of Medicine, observe. Mrs. Miller, of Morgantown, is Secretary of the West Virginia Tuberculosis and Respiratory Disease Association which recently presented to WVU a fellowship grant for respiratory disease research and training in the amount of $10,000 a year for a three-year period. Doctor Reid, Chief Resident in the Department of Medicine, is this year's recipient.

Protecting a reputation is as important as building one.



That's why there's a special program for loss control and education in the WVSMA Liability Insurance Package from Ætna Life & Casualty. How does it help you? By giving you information on losses. Information about actual claims and suits, potential sources and causes of malpractice, even suggestions as to how claims might be prevented. When you're better informed, you're better able to avoid a malpractice incident and thus protect your reputation. What's more, your total insurance costs may be significantly reduced through a special dividend feature.

Of course, you also get broad liability protection under Ætna's plan. Protection that includes professional, office premise and catastrophe liability. It can even be extended to cover your professional equipment. Find out more about this important package of liability insurance. It's officially endorsed and recommended by the West Virginia State Medical Association. Contact your WVSMA office or your nearest Ætna Life & Casualty agent.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

LEGISLATION providing federal aid for establishment of a limited number of experimental Health Maintenance Organizations bills advanced in Congress. The House bill was much smaller in scale (five years, $240 million, compared to $805 million) than one passed by the Senate.

In a report on the HMO bill, the House Commerce Committee discussed HMO's and their possible future role in the health delivery. No specific number limitation was set in the House bill, but "it is anticipated that the limit of authorizations to $240 million and the reality of the budget and appropriation process will provide an effective ceiling on the number of HMO's which could be established . . . Generally, however, the committee would anticipate that this legislation would be used to bring to the operating stage approximately 100 new HMO's."

Five-Year Cut Off Stressed

The report stressed a five-year cut off. "All federal assistance to all assisted HMO's will be completed by the end of five years for which authority is given. Thus, there will be no need to extend or renew this legislation in order to meet outstanding commitments."

After a discussion of "many arguments in favor of HMO's," the report said the committee "is concerned about the fact that HMO's (pre-paid group practice, contract practice, etc.) have not grown more rapidly than has been the case." The committee said it hoped the HMO program would clarify many problem areas, including such basic questions as "will federal assistance to HMO's work?" Other matters of concern were listed as whether federally-aided HMO's will be able to survive without federal help; how well will such organizations serve the poor, chronically ill and aged; how will they work in ghettos and rural areas; what about consumer acceptability, quality of services, etc.

Noting that an HMO operates under an income limit (the premiums paid), the committee said one fear is that "it would be possible for an HMO to respond to this limit by discouraging the utilization of its services. For example, the committee is concerned with the possibility that elective surgery such as cataract extractions in elderly people, might be delayed in situations where an HMO is experiencing higher than expected utilization. These practices are to be discouraged."

Cautioning against allowing an HMO to have a monopoly anywhere, the Committee said:

"The heterogeneity of the HMO's envisioned by the committee is the key characteristic of the HMO program authorized by this legislation and deserves particular comment.

"In preparing the legislation, the committee has attempted not to describe exhaustively or in detail a single 'proper' system for the delivery of health services. The legislation defines desirable qualities for any system for health care delivery and offers to support any HMO which includes these qualities; however, it may be structured or organized in detail. *Thus, the HMO program sponsored by this legislation would not represent a single monolithic or federally-controlled health system, but a series of additions to our existing pluralistic system.*"

The Committee said that one reason there are few HMO-type programs operating now "is the high cost of planning, development and initial operations. It has been estimated that the group practice model requires as many as 30,000 enrollees before the plan breaks even with as much premium income as expenses. Planning costs for this type of HMO can go up to a half million dollars. Operating deficits until the break-even point can amount to $2-3 million."

Unlike the Senate bill, the House legislation does not pre-empt state laws that restrict formation of HMO's. The reason given by the House Commerce Committee was "the rapid change already underway in state legislation designed to remove these barriers . . . (with) . . . approximately 20 states have already adopted legislation specifically authorizing HMO's."

Retirement Savings Restriction

The outlook in Congress for a new restriction on retirement savings of professional service corporations and a companion liberalization of the Keogh plan for the self-employed was cloudy. Opposition to the limitation on the professional service corporations was reported strong in the House, though the Senate was expected to approve it.

The Senate Finance Committee said in its report on the bill that "it is contended that the present

(Continued on Page XIX)

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TEODORO C. DELA CRUZ, M. D.

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STEVE J. MISAK, M. D.

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Robert E. O'Connor, M.D.
Diplomate, American Board of Ophthalmology

Moseley H. Winkler, M.D.
Diplomate, American Board of Ophthalmology

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Oncology

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John A. B. Holt, M.D.
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Inez Maggio, CRNA
Muriel Dodds, CRNA

Annual Reports *

Committee on Aging

This is the fourth report to be presented by this Committee on Aging to the West Virginia State Medical Association. Some of the following recommendations have been included in previous reports:

The Transportation Stamp Program which was recommended in each of the three previous reports appears to have struck pay dirt. At the Chamber of Commerce luncheon at the Hotel Morgan in Morgantown, West Virginia, June 29th, 1973, Gov. Arch A. Moore, Jr., announced that a Transportation Stamp Program, similar to the Food Stamp Program, would be implemented and be in operation within 90 days. Funds are being provided for this project by the Office of Economic Opportunity in excess of four million dollars. This program will be a Godsend to our aging and incapacitated citizens. The Governor is to be commended for taking the initiative in providing this worthwhile service. If it proves a success it will be a model for the other 49 states.

There is a shortage or absence of physicians in some sections of West Virginia. Last year we recommended that the State Medical Association set up a Committee to be called the Placement and Recruitment Committee, whose function would be to help procure family physicians for areas in which there is an urgent need for this service.

There is another suggestion for our State Medical Association. We recommend that each component medical society be authorized to set up a committee on aging. This committee should consist of the president, vice-president and secretary, and its functions should be spelled out in the authorization.

Many medical students receive grants in aid or student loans. These funds come from many sources. Apparently no strings are attached to these grants or loans such as would require the recipient to practice his profession in a designated community in West Virginia. Such a requirement should be stipulated in the contract for loans. If the loan is high in amount, the requirement should also be high.

At the present time we have many foreign-trained physicians in West Virginia hospitals. Many of these physicians do not have a West Virginia license and many are not citizens. It might be worthwhile to explore the possibility of subsidizing some medical students in one or more responsible medical schools in foreign countries. These graduates would then be able to return to the United States and be licensed to practice medicine the same as if they graduated from American medical schools.

The West Virginia University School of Medicine is still in the process of setting up a Department of Family Practice. Dr. Clark K. Sleeth is in charge of the planning for a Department of Family Practice and the employment of a Director. This will be accomplished soon. The residency program will begin July 1, 1974.

The requirements for a physician specializing in family practice are on a par with many other specialties. This means that the present generation of the Aging citizens would receive very little benefit from the program during the next eight to ten years.

There is a possibility that at some future date a second medical school may be located in Huntington and be a part of Marshall University. If this should come to pass, it is recommended that in the setting up of a staff for this school, first priority should be given to the establishment of a Department of Family Practice.

The WVU School of Medicine is continuing to graduate more medical students. The original plan was to graduate 60 students each year. There were 74 graduates in this year's class. Plans are being employed to entice these graduates to locate in West Virginia. One is the Family Practice Training Program in which four state hospitals participate. Another is the fourth-year program which encourages these senior students to spend half of the year in one of the approved state hospitals which participate in this training program. Communities and county medical societies should take more interest in these fourth-year medical students. They should be invited to attend the Annual Meeting of the State Medical Association.

The Area Health Education Center, federally funded to extend health education at all levels, has been set up in Charleston and is directly connected with the West Virginia School of Medicine.

The number of Senior Citizens is increasing year by year. There are over twenty million Americans in this class and nearly all receive Social Security benefits. Medicare provides limited hospital coverage. Peer review and limitation of stay in the hospital tend to interfere with the patient-physician relationship. All should carry additional hospital insurance. More out-patient care and drugs should be provided. *More approved nursing homes are a must.*

The family physician is important to this aging group. The community clinic will help to fill in the gap. This older group of Senior Citizens will continue to have difficulty in adjusting to the assembly line practice of medicine. They appreciate the physician whom they can call their family doctor.

Respectfully submitted,

Eldon B. Tucker, M. D.
Chairman
Myer Bogarad, M. D.
Richard D. Hamilton, M. D.

July 26, 1973

(Continued on Page XVIII)

*Other annual reports were published in the August, 1973 issue of The Journal.

General and Thoracic Surgery
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James A. Gardner, M. D.

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S. A. Zahir, M. D.
Mario C. Ramas, M. D.

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Carl McGraw, Ph. D.

Don Phillips, Administrator
George K. White
Asst. Administrator

Insurance Committee

A meeting of the Insurance Committee was held at The Greenbrier in White Sulphur Springs on August 23, 1973, during the 106th Annual Meeting of the West Virginia State Medical Association.

Present were Mr. Edward H. Morgan, Secretary of Aetna Life and Casualty Company of Hartford, Connecticut; Mr. F. M. Taylor of Charleston, State Coordinator for the Professional Liability Insurance Program for the same company; and Mr. John Pecorino and Dr. David C. Kellsey, also of Aetna. Also present was Mr. W. Gaston Caperton, III, of the McDonough-Caperton-Shepherd-Goldsmith firm in Charleston.

Members of the Insurance Committee present were Drs. Upshur Higginbotham of Bluefield, Buford W. McNeer of Hinton, and C. A. (Carl) Hoffman of Huntington.

At the outset, it was pointed out that the program for the West Virginia State Medical Association with the Aetna Life and Casualty of Hartford, Connecticut, was implemented about a year ago The members concurred in the belief that the program was on a firm foundation, and would continue in its progression to be a valuable benefit for the member physicians of our State.

The following items were discussed:

(1) It was suggested that Mr. Taylor by letter through *The Journal* notify all of our practicing members that it would be advantageous—from all points of view—if members would notify Mr. Taylor if they become aware of an instance which might possibly lead to a malpractice claim or litigation so that any feasible defensive measures may be taken by our Committee.

(2) It also was recommended that the President of our State Medical Association appoint a committee consisting of one or two members from each geographic area, but not necessarily with regard to the various specialties of medicine which members might be engaged for we may call in consultants in any litigation in which a defendant member is involved.

(3) Some discussion was given to consideration of adding to our malpractice program a catastrophic medical coverage for our physicians up to the amount of $250,000 which would be on or above our present major medical coverage. Although we voiced the hope that Aetna could provide the coverage, it appeared to those members present it would be better to have it under the umbrella of our other disability and medical coverage. We suggested that Mr. Taylor and Mr. Caperton discuss this problem and report to the Committtee.

(4) Mr. Morgan pointed out the importance of financial disclosure to the Committee. We discussed our present response to date, and it was agreed that an increased premium was warranted. Although the premium for catastrophe will be lowered, the basic coverage is increased with hope for an average increase of 12 per cent.

(5) When the question was raised as to the high risk in the urban community, Mr. Taylor pointed out that the claims which had been reported since the program began were limited to small communities.

(6) The question was raised as to whether our premium was based on both the physician and hospital experience. We were told this was not true

(Continued on Page XXIII)

Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1972

July 25	George L. Viewig	Wheeling
Aug. 16	Lawrence F. Boland	Georgetown, Ky.
Sept. 1	John Stone Meier	Wheeling
Sept. 3	Abraham A. Seletz	Charleston
Sept. 12	Guy Stalnaker	Glenville
Oct. 4	Joel Allen	Charleston
Oct. 21	Emory E. Jones, Jr.	Mount Hope
Oct. 30	E. Lyle Gage	Bluefield
Oct. 31	Samuel J. Morris	Morgantown
Nov. 10	Bernard S. Clements	Bluefield
Nov. 14	Arnold Wilson	Pasadena, Fla.
Nov. 22	Clement A. Smith	Morgantown
Nov. 29	Everett W. Squire	Charleston
Dec. 3	Frank V. Langfitt	Clarksburg
Dec. 4	Ernest M. Wilkinson	Pineville
Dec. 5	Robert O. Canada, Jr.	White Sul. Sprgs.
Dec. 8	William T. Owens	Clarksburg
Dec. 24	Edwin J. Humphrey, Jr.	Huntington
Dec. 26	Howard G. Weiler	Wheeling

1973

Jan. 9	Thomas S. Sexton	Springfield, Mass.
Feb. 4	Henry L. Criss	Fairmont
Feb. 7	Dennis J. Cronin	Huntington
Feb. 9	James R. Gatherum	Pocahontas, Va.
Feb. 24	Forest A. Cornwell	Beckley
Feb. 25	Delmer Jencks Brown	Parkersburg
Mar. 6	Willard F. Daniels	Huntington
Apr. 22	Albert Eugene Harrington	Elkins
May 7	Andrew James Niehaus	Wheeling
May 7	Ralph Homer Boice	Parkersburg
May 11	Cecil A. Jarrell	South Charleston
May 23	Thomas H. McGavack	Martinsburg
June 17	Charles E. Hamner	Houston, Texas
July 7	John S. Boling	Lubbeck, Texas
July 15	Evelyn A. Meadows	Weston
July 23	Oliver H. Brundage	Parkersburg
Aug. 2	B. I. Golden	Elkins
Aug. 6	Maynard P. Pride	Morgantown
Aug. 7	Theodore C. Giffin	Keyser
Aug. 23	E. V. Nutter	Gauley Bridge

Respectfully submitted,

William H. Lively
Executive Secretary

(Continued from Page XIV)

law in the retirement plan area creates an artificial incentive for the incorporation of businesses which more traditionally, and perhaps more appropriately, have been conducted in unincorporated form."

The committee restricted the amount an incorporated professional could save for retirement purposes and receive federal income tax deferred on to $7,500 a year and not more than 15 per cent of income. The Keogh plan was liberalized to the same levels.

Noting that in recent years all states have adopted special incorporation laws which allow professional corporations, the committee said these "have been used increasingly by groups of professional persons, primarily to obtain the more favorable tax treatment for pensions generally available to corporate employees." The Internal Revenue Service's adamant opposition to these corporations and refusal to recognize them in the so-called Kintner regulations was rejected by the courts until "the service has now acquiesced and generally recognized these professional corporations as corporations for income tax purposes."

The committee said "the formation of professional corporations, a practice which has proliferated enormously in recent years, has had the effect of circumventing the limitations which Congress intended to impose on deductible contributions by persons who are essentially, in most respects, self-employed."

Explaining why it didn't impose any limit on regular corporation tax deferrals for high-salaried executives, the committee said that in corporate plans a "much larger percentage of the contributions and benefits go to the 'rank and file' employees." This "financial drag effect tends to impose practical restrictions. . . ."

November Courses Listed By Cleveland Clinic

Two postgraduate courses will be held by the Cleveland Clinic Educational Foundation in November. They are "Pediatric Endocrinology," to be held November 7 and 8; and "Gastroenterology for the Practicing Physician," November 14 and 15.

Guest speakers for the first course will include Drs. Alvin B. Hayles, Mayo Medical School, Rochester, Minnesota; Sam Spector, Wyler Children's Hospital, University of Chicago Hospital and Clinics; and Robert Schwartz, Case Western Reserve University, Cleveland. The registration fee is $60.

Speakers for the other course will include Drs. Gary M. Gray, Stanford University; Harold P. Roth, Case Western Reserve University; John T. Sessions, Jr., University of North Carolina; Marvin H. Sleisenger, University of California, San Francisco; and Jack A. Vennes, University of Minnesota. The registration fee is $80.

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Obituaries

CHARLES E. HAMNER, M.D.

Dr. Charles E. Hamner of Houston, Texas, formerly of Huntington, died on June 17 in Houston. He was 85.

A native of Beulah, Louisiana, Doctor Hamner formerly was a psychiatrist at Huntington State Hospital. He also had been a staff member at Spencer State Hospital and Columbus (Ohio) State Hospital. He moved to Texas in 1970.

Doctor Hamner was a graduate of Louisiana State University and received his M.D. degree in 1911 from the Medical Department, Tulane University. He also held a D.Ph. degree from the School of Tropical Medicine, Tulane University. He interned at Charity Hospital in New Orleans.

Doctor Hamner was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

* * * *

THEODORE C. GIFFIN, M. D.

Dr. Theodore C. Giffin of Keyser, who had been in family practice there since 1924, died on August 7 in a Martinsburg hospital following a lengthy illness. He was 72.

A native of Trone, Virginia, Doctor Giffin attended public schools in Keyser and Rowlesburg. He was graduated from the two-year medical school at West Virginia University in 1921 and received his M. D. degree in 1923 from the University of Maryland School of Medicine. He received a 50-year certificate in conjunction with the annual alumni banquet of the medical school last May 31.

Doctor Giffin was honored in 1969 at a testimonial dinner in Keyser which was attended by more than 200 persons. Among the speakers was Congressman Harley O. Staggers.

He served his internship and residency at Mercy Hospital in Baltimore. He was a member and Past Secretary of the Potomac Valley Medical Society, and a member of the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two daughters, Mrs. Sally Lou Wilson of McCoole, Maryland and Mrs. Mary Elizabeth Twigg of Cumberland, Maryland; a brother, Dr. Paul Giffin, Keyser dentist; a sister, Mrs. Neva Law of Wheeling, and nine grandchildren.

* * * *

EDGAR V. NUTTER, M. D.

Dr. Edgar V. Nutter, a family physician in Gauley Bridge for 31 years until his retirement two years ago, died August 23 in a Montgomery Hospital. He was 73.

A native of Nallen (Fayette County), Doctor Nutter was a graduate of the former New River State College, now West Virginia Tech. He received his M. D. degree in 1929 from the University of Louisville Medical School.

Doctor Nutter was a member and Past President of the Fayette County Medical Society (1950-51), and a member of the West Virginia State Medical Association.

Survivors include the widow; two daughters, Mrs. Pam Dillon of Greensboro, North Carolina and Mrs. Bess McGill of Manhattan Beach, California; two brothers, John Nutter of Powellton and Clyde Nutter of Norfolk, Virginia; one sister, Mrs. Myrtle Haynes of Rainelle, and three grandchildren.

PG Course On 'Sleep' Scheduled At MCV

A postgraduate course on "Sleep As an Entity in Medical Practice" will be held on October 24 at the Medical College of Virginia, in Richmond.

The faculty will include Drs. Harold Goldberg, Director, West-Ros-Park Mental Health Center, Boston, Massachussetts; David R. Hawkins, Professor and Chairman, Department of Psychiatry, University of Virginia Medical Center, Charlottesville; James L. Mathis, Professor and Chairman, Department of Psychiatry, Medical College of Virginia; and Fitzhugh Mayo, Professor and Chairman, Department of Family Practice, MCV.

There is no registration fee. Advance registration, however, is requested. All lectures will be held in Baruch Auditorium of the Egyptian Building, 13th and Marshall Streets. The program will begin at 9 A.M. and conclude at 4 P.M.

Radiology:
Karl J. Myers, M. D.

Pathology:
Fulvio Franyutti, M. D

Surgery:
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
T. H. Chang, M D
J. W. Woodford, M. D.

Gynecology and Obstetrics:
Raymond W. Cronlund, M. D.

Internal Medicine:
E. G. Guy, M. D.
B. G. Thimmappa, M. D.
Karl J. Myers, Jr., M. D.

Pediatrics:
D. F. Manger, M. D.
E. G. Kreider, M. D.

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Resolutions

Your Committee on Resolutions has carefully considered the resolutions offered at the first session of the House of Delegates on Wednesday afternoon, August 22, 1973.

We are happy to report that a number of interested physicians appeared at a meeting of the Committee held on Thursday afternoon, August 23, 1973, and discussed in detail the resolutions pending before the Committee.

The cooperation of those physicians present was most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearings.

Mr. President, your Committee assures the members of the Association that the one and only consideration that has guided the Committee in its deliberations has been the criteria as to whether each of the resolutions were or would be to the best interests of the entire medical profession in West Virginia.

Mr. President, your Committee paid special attention to Resolution No. 7, in re PSRO and Support for the West Virginia Medical Institute, Inc., in Implementation of the New Federal Law which was offered by the Council.

The Committee voted unanimously to recommend to the House of Delegates that Resolution No. 7 be approved by the House of Delegates in its original form. (For the text of this resolution please see story in the general news section of this issue of *The Journal*).

Resolution No. 2, in re Council Instruction to AMA Delegates on Key Issues before the AMA House of Delegates which was offered by The Kanawha Medical Society.

The Committee voted unanimously to recommend the adoption of Resolution No. 2 as originally introduced.

Mr. President, your Committee devoted considerable time to consideration of Resolution No. 3 in re the Continuing Education Program at the West Virginia University School of Medicine.

The Committee unanimously voted to recommend that the title of Resolution No. 3 be amended to read as follows: "In re Prompt Establishment of Area Health Education Centers throughout West Virginia by the West Virginia University School of Medicine."

Also, the Committee recommended that the first resolving clause be amended to read as follows: "THEREFORE, BE IT RESOLVED, That the House of Delegates of the West Virginia State Medical Association do hereby endorse and call for prompt establishment of other area health education centers by the West Virginia University Medical Center and that these centers should use the Charleston Area Health Education Center as a model and should emphasize continuing education for all health professions."

Resolution No. 5, in re Increasing the Number of Scholarships Awarded Annually by the West Virginia State Medical Association from Two to Four, which was offered by The Kanawha Medical Society.

Mr. President, the Committee voted to recommend that the third WHEREAS of Resolution No. 5 be amended as follows: "WHEREAS, A majority of the recipients of said scholarships who have completed training have remained in West Virginia for the practice of medicine."

Mr. President, your Committee considered in detail Resolution No. 6 calling for an increase in annual dues in the amount of $6 to finance two additional scholarships.

Following considerable discussion, Mr. President, the Committee voted unanimously to recommend to the House of Delegates that Resolution No. 6 be tabled and any action in re a dues increase be held in abeyance until the 1974 Annual Meeting.

Mr. President, there was considerable discussion concerning Resolution No. 4 in re Repeal of the Federal PSRO Law #92-603, Sub-Section 249-F, which was offered by The Kanawha Medical Society.

The Committee voted unanimously to recommend to the House of Delegates that the resolving clause be amended as follows: "THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association expresses grave reservations with regard to PSRO legislation, and recognizes that repeal or modification ultimately may be required to preserve the high quality of patient care; that the West Virginia State Medical Association should oppose any facets of this current legislation which might bring about deterioration in the quality of care; should publicize such damaging facets; and should place highest priority on developing and pursuing appropriate amendments to preserve the high quality of patient care."

Mr. President, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on Thursday afternoon, August 23, 1973.

Your Chairman personally expresses his gratitude to the members of the Committee for their patience, enthusiasm, wisdom and valuable time devoted to

(Continued on Page XXIII)

Book Reviews

HANDBOOK OF MEDICAL TREATMENT—Milton J. Chatton, M.D. Lange Medical Publications, Los Altos, California 94022. 13th Edition. Pp. 648. 1973.

This 600-page compendium by Doctor Chatton and associated authors will be found useful for ready reference to many problems of general medicine.

There are 33 topics discussed including an up-to-date outline of cancer chemotherapy, and there are several helpful appendices including detailed heart lung resuscitation. There are many features on diagnoses and treatment that can be rapidly digested into prompt practical usage.

The book is pocket size and will be useful on the desk, in the hospital, or even in the car for the house callers.

ANNUAL REPORTS—(Continued)

—that our rate was based on physician experience only.

(7) Each county medical society is urged to invite Mr. Taylor to appear before its members and discuss the program. This would include a very strong educational program.

(8) For bookkeeping reasons, it would be better to have our anniversary date on January 1 rather than December 1. It thus may be necessary to bill the members this year for the month of December only, and at the end of the year to bill them for the coming year.

(9) The Committee was assured that as our program becomes more financially sound, they may be able to have a dividend within the next two years.

Respectfully submitted,

C. A. Hoffman, M. D.
Chairman

August 23, 1973.

Other States Represented At Annual Meeting

The 106th Annual Meeting of the West Virginia State Medical Association in August at The Greenbrier attracted physicians from 19 other states and the District of Columbia, with 11 of the visitors from Ohio.

Other states represented included Tennessee, California, Florida, North Carolina, Pennsylvania, Louisiana, Wisconsin, Maryland, Kentucky, Indiana, Arizona, Alabama, Virginia, Connecticut, New York, Delaware, Michigan and Illinois.

House of Delegates Adopts One Amendment to By-Laws

The House of Delegates of the West Virginia State Medical Association adopted the following amendment to the By-Laws during the 1973 Annual Meeting at The Greenbrier.

Amend Chapter VIII, Section V, Sub-Section (v) by deleting the entire Sub-Section and inserting in lieu thereof the following: "Venereal Disease. The Venereal Disease Committee shall act in an advisory capacity to the Council and shall cooperate to the fullest extent with the Bureau of Venereal Disease Control of the State Department of Health, to the end that the treatment and control of venereal disease may be rendered as effective as possible. The Committee shall also foster research work and initiate surveys particularly with reference to industry, and shall report the results of such surveys to the medical profession in this state."

Proposed Constitutional Amendment

One proposed amendment to the Constitution was offered at the first session of the House of Delegates. The amendment will be submitted to the House of Delegates for final action at the 107th Annual Meeting at The Greenbrier next August. The proposed amendment reads as follows:

Amend Article VI, Section 1, by deleting in the sixth line after the word "Treasurer," the words, "ex officio."

(Adoption of this amendment would make the Treasurer of the Association a voting member of the Council).

Association To Award Two Additional Scholarships

The House of Delegates of the West Virginia State Medical Association voted to increase from two to four the number of $4,000 scholarships to be awarded annually by the Association to students entering the West Virginia University School of Medicine. The recipients of the scholarships receive $1,000 for each of the four years at the School of Medicine.

The action was taken at the final session of the House during the Association's 106th Annual Meeting in White Sulphur Springs.

RESOLUTIONS—(Continued)

the study of the resolutions. In addition to your Chairman, the members of the Committee participating were Drs. George R. Callender, Jr., and Seigle W. Parks, both of Charleston; Harry S. Weeks, Jr., of Wheeling; and Mr. William H. Lively and Mr. Charles R. Lewis, members of the staff.

Respectfully submitted,

Richard E. Flood, M. D.,
Chairman

White Sulphur Springs.
August 25, 1973.

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Robert W. Leibold, M. D.
Robert T. Brandfoss, M. D.
A. Athori, M. D.

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Dermatalagy:
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Sheldan Widlan, M. D.

Internal Medicine:
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Albert M. Volentine, M. D.
C. A. Vasquez, M. D.

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James P. Frum, M. S.

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Danna Bryan

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Brenda Muklewicz, R. N.
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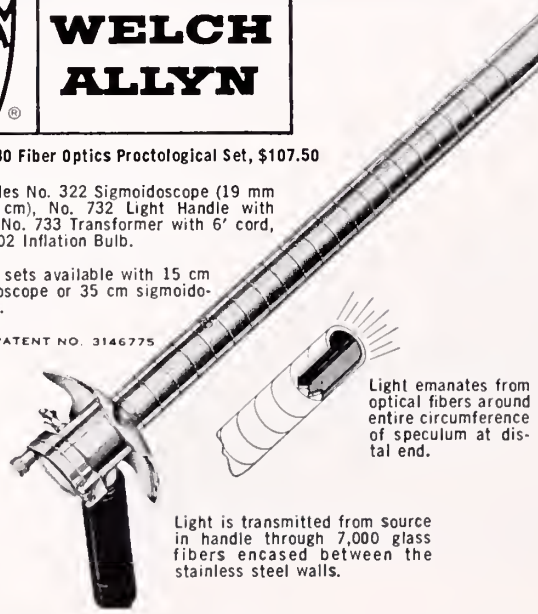

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GENERAL SURGEON WANTED—Must have necessary qualities for advancement to Chief of Staff or Medical Director. Salary open. Medium size hospital in Southern West Virginia. Fully accredited with modern furniture and equipment. Contact CAW, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

NOTICE—Grafton City Hospital is pleased to announce its affiliation with Alderson-Broaddus College as a primary institution for the training of physicians assistants and nurses. Needed to augment the medical staff are a general practitioner, internist and an obstetrician-gynecologist. New hospital will be completed within three months and the training program will start in September 1973. Salary and subsidies can be arranged. Contact Wallace B. Murphy, M.D., Chief of Staff, Grafton City Hospital, Grafton, West Virginia 26354.

FAMILY PHYSICIANS—To practice at Jackson General Hospital and in the Ripley-Ravenswood area of West Virginia. Excellent opportunities in a prosperous area with tremendous growth potential. Salary guarantee for first year. Contact Administrator, Jackson General Hospital, Ripley, West Virginia 25271. Telephone: (304) 372-2731.

WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mrs. J. Carl Rinehart, Pennsboro, W. Va.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

WANTED—General practitioner, internist, pediatrician and emergency room physician to associate with other specialties in small town in Southern West Virginia. Accredited 82-bed hospital and new clinic building. Excellent working conditions. Short-term appointments available. Contact Jorge J. San Pedro, M.D., Man, W. Va. (304) 583-6541.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

URGENTLY NEEDED—General practitioners and pediatricians for a community of 22,000. Large industry, good schools, 5-year-old 67-bed general hospital, including a one-year-old 14-bed pediatric section. Community situated on federal interstate and very accessible in all directions. Contact LDT, The W. Va. Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

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WANTED—Two general practitioners in Marlinton, Pocahontas County. A 42-bed general hospital is available. Successful practice practically assured and assistance will be offered in locating office space. Call Mr. S. E. Drumm, Administrator, Pocahontas Memorial Hospital in Marlinton, collect, for particulars (304) 799-4193.

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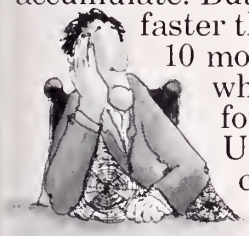

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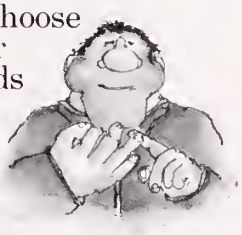

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All you have to do is sign up for the Payroll Savings Plan at work. Then an amount you specify is set aside from your paycheck each month and used to buy Bonds. While you use your take-home pay for immediate needs, you're also building a nice nest egg. Automatically.

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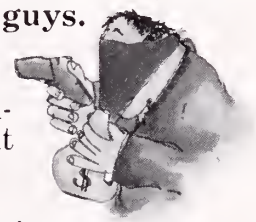
Bonds are replaced if destroyed, lost or stolen. With no red-tape hassles. And at no cost to you.



They come in all sizes, but they fit everyone.
Bonds don't come with hearts or lace, but they offer a lot of hope, love and encouragement. For someone special, Bonds are a Gift Certificate of the Imagination.

U.S. Savings Bonds. What it comes down to is taking stock in yourself.

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Limited Facilities for the Aging

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Usage: Apply where it hurts with gentle massage. May be repeated as often as necessary. A first aid in injuries, relieving pain and discouraging infection. Useful in industrial clinics—collegiate and professional athletic training programs.

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Dispensed in 4 oz. bottles, 6 oz. aerosol spray, pint and half gallon bottles.

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How strong must a tranquilizer be for severe anxiety?

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The achievement of desired therapeutic results is often a function of the dosage *strength* as well as the drug's intrinsic action. Thus, when anxiety is *severe*, the 25-mg strength of Librium frequently provides the necessary antianxiety action with a minimum of unwanted adverse reactions. Librium 25 mg is a convenient dosage form for the relief of severe, incapacitating anxiety, specifically formulated to supplement your counsel and reassurance.

Benefits-to-risks ratio permits higher dosage

For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.

basic support in severe anxiety

Librium® 25 mg (chlordiazepoxide HCl)

1 capsule t.i.d./q.i.d.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Before prescribing, please consult co plete product information, a summary of which follows:

Indications: Relief of anxiety and tensi occurring alone or accompanying various dise states.

Contraindications: Patients with know hypersensitivity to the drug.

Warnings: Caution patients about possi combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, cau patients against hazardous occupations requiri complete mental alertness (*e.g.*, operating mac ery, driving). Though physical and psychologi dependence have rarely been reported on reco mended doses, use caution in administering to addiction-prone individuals or those who mig increase dosage; withdrawal symptoms (inclu convulsions), following discontinuation of th drug and similar to those seen with barbiturat have been reported. Use of any drug in pregn lactation, or in women of childbearing age req that its potential benefits be weighed against i possible hazards.

Precautions: In the elderly and debilita and in children over six, limit to smallest effec tive dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gr ally as needed and tolerated. Not recommend in children under six. Though generally not r ommended, if combination therapy with othe psychotropics seems indicated, carefully consi individual pharmacologic effects, particularly use of potentiating drugs such as MAO inhibi and phenothiazines. Observe usual precaution presence of impaired renal or hepatic functio Paradoxical reactions (*e.g.*, excitement, stimula and acute rage) have been reported in psychia patients and hyperactive aggressive children. Employ usual precautions in treatment of an states with evidence of impending depression suicidal tendencies may be present and protect measures necessary. Variable effects on blood coagulation have been reported very rarely i patients receiving the drug and oral anticoagu lants; causal relationship has not been establis clinically.

Adverse Reactions: Drowsiness, ataxia confusion may occur, especially in the elderly debilitated. These are reversible in most instar by proper dosage adjustment, but are also occa sionally observed at the lower dosage ranges. I few instances syncope has been reported. Also countered are isolated instances of skin erupti edema, minor menstrual irregularities, nausea constipation, extrapyramidal symptoms, incre and decreased libido—all infrequent and gene controlled with dosage reduction; changes in patterns (low-voltage fast activity) may appea during and after treatment; blood dyscrasias (cluding agranulocytosis), jaundice and hepati dysfunction have been reported occasionally, ing periodic blood counts and liver function t advisable during protracted therapy.

Supplied: Librium® Capsules containi 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

the West Virginia Medical Journal

FICIAL ORGAN OF
VEST VIRGINIA STATE
ICAL ASSOCIATION

69 No. 11

7th Mid-Winter Clinical Conference
January 18-20, 1974

NOVEMBER 1973

Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counseli

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium zepam) part of your treatment n, check on whether or not the ent is presently taking drugs , if so, what his response has n. Along with the medical and ial history, this information can o you determine initial dosage, possibility of side effects and ultimate prospects of success ailure.

While Valium can be a most pful adjunct to your counseling, hould be prescribed only as long xcessive psychic tension per- s and should be discontinued en you decide it has accom- hed its therapeutic task. In eral, when dosage guidelines followed, Valium is well rated (see Dosage). For con- nience it is available in 2-mg, 5-mg l 10-mg tablets.

Drowsiness, fatigue and ataxia e been the most commonly re- ted side effects.

Until response is determined, ients receiving Valium should cautioned against engaging in ardous occupations requiring nplete mental alertness, such driving or operating machinery.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

NOVEMBER
1973

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The
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acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

Tandearil® helps take the heat off

oxyphenbutazone NF

Geigy

Tablets of 100 mg.
Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
(B)98-146-800-F (10/71)
For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TA 9041

More than sleep

your choice of sleep medication is wisely based on more than sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dal (flurazepam HCl); no depression of cardiac or respiratory fu was noted in patients administered recommended or higher for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldc quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hou without need to repeat dosage

No sleep cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pa given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to r dosage during the night.

›eep with ›nsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

›almane (flurazepam HCl) is a distinctive sleep medication—a ›diazepine specifically indicated for insomnia. It is not a barte or methaqualone, nor is it related chemically to any other ble hypnotic.

›hen your evaluation of insomnia indicates the need for a sleep ›ation, consider Dalmane—a single entity nonnarcotic, non-urate agent proved effective and relatively safe for relief of nia.

DALMANE®
(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage. 15 mg may suffice in some patients. *Elderly or debilitated patients.* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE

ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulation

The American Academy of Dermatol

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associa

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

t Statement on Antisubstitution Laws and Regulations

The purpose of this statement is firm the support of the participat- organizations for the laws, regula- s and professional traditions which ibit the unauthorized substitution ug products.

Traditionally, physicians, den- and pharmacists have worked eratively to serve the best inter- of patients. Productive coopera- has been achieved through ual respect as well as a common cern for the ideals of public ice. This mutual respect has been ected, in part, by joint support the years for the adoption and rcement of laws and regulations cifically prohibiting unauthorized stitution and encouraging joint ussion and selection of the ce of supply of drug products. basic principles of medical, den- nd pharmacy practice are thus zed and preserved in the interest atient welfare.

The antisubstitution laws have obstructed enhancement of the essional status of pharmacy any e than they have in and of them- es guaranteed absolute protec- from unsafe drugs, or freed sicians, dentists and pharmacists n their responsibilities to patients. practical matter, however, such s and regulations encourage inter- essional communications regard- drug product selection and assure h profession the opportunity to rcise fully its expertise in drug ge, to the advantage of patients.

Physicians and dentists should rged to increase the frequency l regularity of their contacts with rmacists in selection of quality g products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

ROCHE announces new BACTRIM™

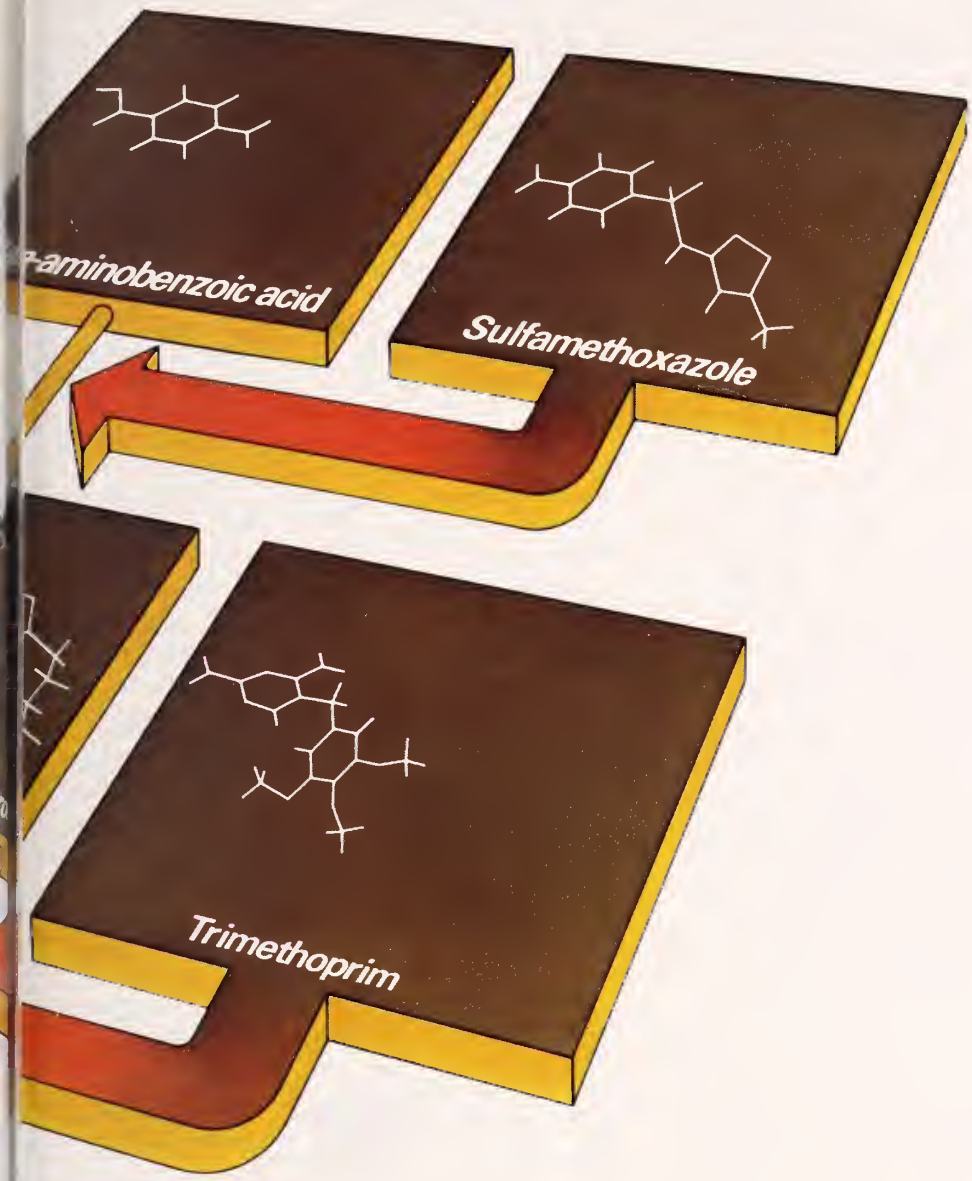
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections – primarily pyelonephritis, pyelitis and cystitis – when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.



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new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

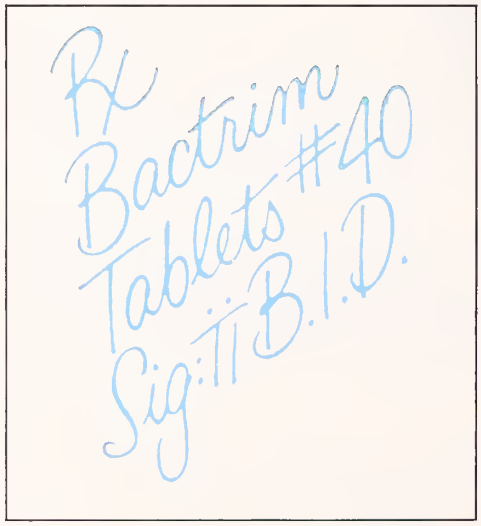
Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

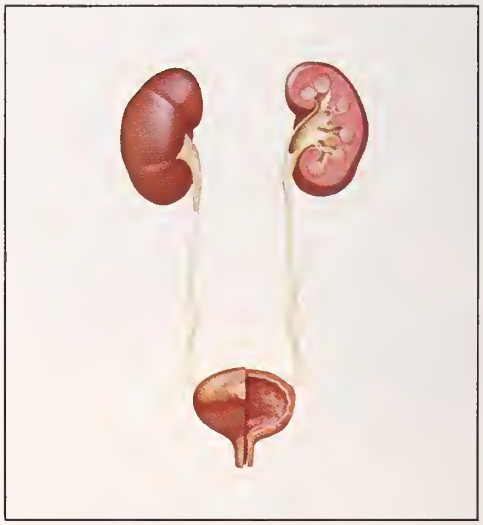
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
†4 patients not available for evaluation at day 10.





new BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

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Before prescribing, please consult complete product information on facing page.

C plete Product Information:

D ription: Bactrim is a synthetic antibacterial combination prod- available in scored light-green tablets, each containing 80 mg ethoprim and 400 mg sulfamethoxazole.

ethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. a white to light-yellow, odorless, bitter compound with a molec- weight of 290.3.

amethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is lmost white in color, odorless, tasteless compound with a mo- lar weight of 253.28.

ons: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis ihydrofolic acid by competing with *para*-aminobenzoic acid. ethoprim blocks the production of tetrahydrofolic acid from di- rofolic acid by binding to and reversibly inhibiting the required yme, dihydrofolate reductase. Thus, Bactrim blocks two con- itive steps in the biosynthesis of nucleic acids and proteins ential to many bacteria.

itro studies have shown that bacterial resistance develops more ly with Bactrim than with trimethoprim or sulfamethoxazole e.

itro serial dilution tests have shown that the spectrum of anti- terial activity of Bactrim includes the common urinary tract ogens with the exception of *Pseudomonas aeruginosa*. The fol- ng organisms are usually susceptible: *Escherichia coli, Kleb- a-Enterobacter, Proteus mirabilis* and indole-positive proteus cies.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

cteria	Trimeth- oprim alone	Sulfameth- oxazole alone	TMP/SMX (1:20) TMP	SMX
cherichia li	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
oteus spp. dole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
oteus rabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
ebsiella- terobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

man Pharmacology: Bactrim is rapidly absorbed following oral ministration. The blood levels of trimethoprim and sulfamethoxa- e are similar to those achieved when each component is given ne. Peak blood levels for the individual components occur one our hours after oral administration. The half-lives of sulfameth- zole and trimethoprim, 10 and 16 hours respectively, are rela- ly the same regardless of whether these compounds are admin- red as individual components or as Bactrim. Detectable ounts of trimethoprim and sulfamethoxazole are present in the od 24 hours after drug administration. Free sulfamethoxazole l trimethoprim blood levels are proportionately dose-dependent. repeated administration, the steady-state ratio of trimethoprim ulfamethoxazole levels in the blood is about 1:20.

famethoxazole exists in the blood as free, conjugated and pro- n-bound forms; trimethoprim is present as free, protein-bound l metabolized forms. The free forms are considered to be the rapeutically active forms. Approximately 44 percent of trimeth- im and 70 percent of sulfamethoxazole are protein-bound in the od. The presence of 10 mg percent sulfamethoxazole in plasma creases the protein binding of trimethoprim to an insignificant gree; trimethoprim does not influence the protein binding of famethoxazole.

cretion of Bactrim is chiefly by the kidneys through both glomer- r filtration and tubular secretion. Urine concentrations of both famethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together in Bactrim, neither sulfamethoxazole nor trimethoprim affects urinary excretion pattern of the other.

lications: Chronic urinary tract infections (primarily pyelonephri- pyelitis and cystitis) due to susceptible organisms (usually *coli, Klebsiella-Enterobacter, Proteus mirabilis*, and, less fre- ently, indole-positive proteus species).

***portant note:* Currently, the increasing frequency of resistant organ- ns is a limitation of the usefulness of all antibacterial agents, espe- lly in the treatment of chronic and recurrent urinary tract infections.**

ntraindications: Hypersensitivity to trimethoprim or sulfonamides. egnancy and during the nursing period (see Reproduction udies).

rnings: Deaths associated with the administration of sulfonamides ve been reported from hypersensitivity reactions, agranulocyto- s, aplastic anemia and other blood dyscrasias. Experience with methoprim alone is much more limited, but it has been reported interfere with hematopoiesis in occasional patients. In elderly tients concurrently receiving certain diuretics, primarily thia- des, an increased incidence of thrombopenia with purpura has en reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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Warnings: Hypercalcemia may occur in immobilized patients, and in patients with breast cancer. In patients with cancer this may indicate progression of bony metastasis. If this occurs the drug should be discontinued. Watch female patients closely for signs of virilization. Some effects may not be reversible. Discontinue if cholestatic hepatitis with jaundice appears or liver tests become abnormal.

Precautions: Patients with cardiac, renal or hepatic derangement may retain sodium and water thus forming edema. Priapism or excessive sexual stimulation, oligospermia, reduced

ejaculatory volume, hypersensitivity and gynecomastia may occur. When any of these effects appear the androgen should be stopped.

Adverse Reactions: Acne. Decreased ejaculatory volume. Gynecomastia. Edema. Hypersensitivity, including skin manifestations and anaphylactoid reactions. Priapism. Hypercalcemia (especially in immobile patients and those with metastatic breast carcinoma). Virilization in females. Cholestatic jaundice.

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*Cecil-Loeb. Textbook of Medicine, Vol. II, ed. 13. Beeson, P. B. and McDermott, W. eds. Philadelphia, W. B. Saunders Co., 1971, p. 1816.

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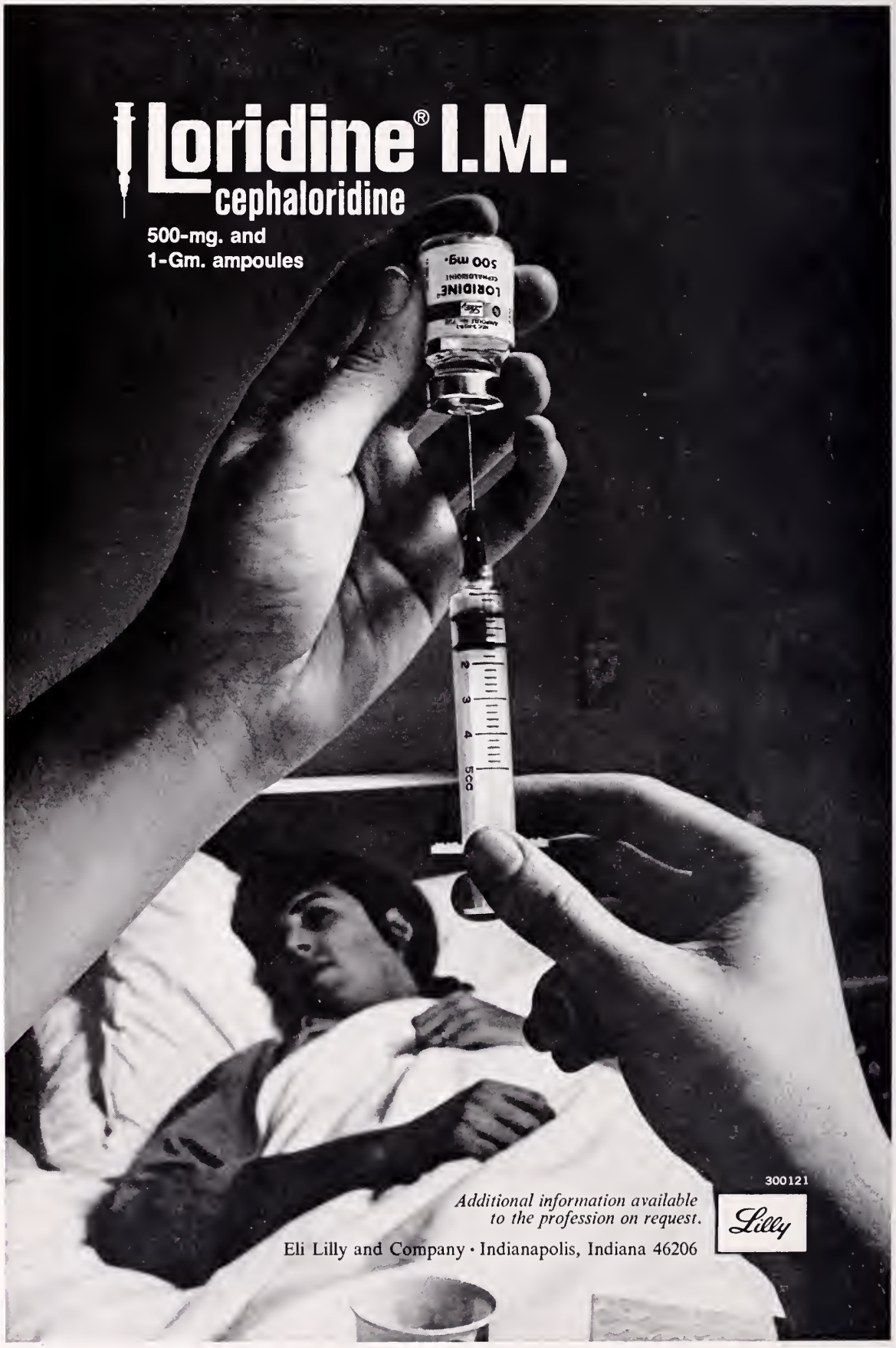
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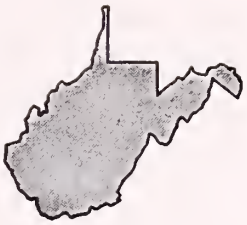

Vol. 69, No. 11 November, 1973

Renal Trauma*
West Virginia University Hospital — Analysis Of 48 Cases (1967-1972)

Stephen Allen Stuppler, M. D.

In this age of high speed vehicular travel, renal injury is no stranger to the hospital emergency room. West Virginia University Hospital is predominantly a referral center which is not geographically situated to reflect the trauma patient load seen in a large city hospital. Interestingly, the local abundance of treacherous secondary roads and poor weather conditions make the hospital trauma case load more representative of a metropolitan hospital. During the 1967-1972 period, 48 patients with various degrees of renal injury were treated at the West Virginia University Hospital. The cases will be classified, analyzed and compared with other trauma series.

Materials and Methods

This study is a retrospective one, which attempts to analyze those 48 cases of renal injury. Renal trauma is generally classified by the type of injury into: (1) contusion, (2) laceration, (3) fragmented kidney or (4) renal pedicle injury.[1] The cases were then examined with reference to symptoms, diagnostic modalities, treatment and outcome.

Results

The 48 cases were grouped into type of renal injury. Contusion accounted for 39 cases; laceration, four cases, and ruptured or fragmented kidneys, five cases. There were no renal pedicle injuries seen in the series (Table 1).

Table 1
Classification of 48 Renal Injuries

Contusion	39
Laceration	4
Fragmented	5
Pedicle Injuries	0

*Presented during the Annual Meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier, White Sulphur Springs, May 3-5, 1973.

The Author

- **Stephen Allen Stuppler, M. D., Department of Surgery, Division of Urology, West Virginia University Medical Center, Morgantown.**

The average patient age was 25.7 years and males outnumbered females 34 to 14. Greater than 90 per cent of the cases were related to the blunt trauma of automobile accidents.

Hematuria and flank pain brought the patient to the attention of the urologist. Gross hematuria was seen in 21 cases of contused kidneys. Lacerated kidneys showed gross hematuria in three out of four cases. Fragmented kidneys revealed gross hematuria in all five cases (Table 2).

Table 2
Hematuria In Renal Injury

	Gross	*Microscopic*
Contusion	18	21
Laceration	3	1
Fragmented	5	0

The renal damage was evaluated by the use of high dose intravenous pyelography either with rapid infusion of 250 cubic centimeters of 25 per cent sodium diatrizoate or one or two cubic centimeters of 50 per cent sodium diatrizoate per kilogram of body weight. Routine pyelographic exposures and delayed films were taken where indicated specifically to evaluate extravasation (Figure 1 a-b). Retrograde pyelography was used only four times and this reflected the unavailability of arteriography at these times (Figure 2). The pyelogram was abnormal in 16 per cent of

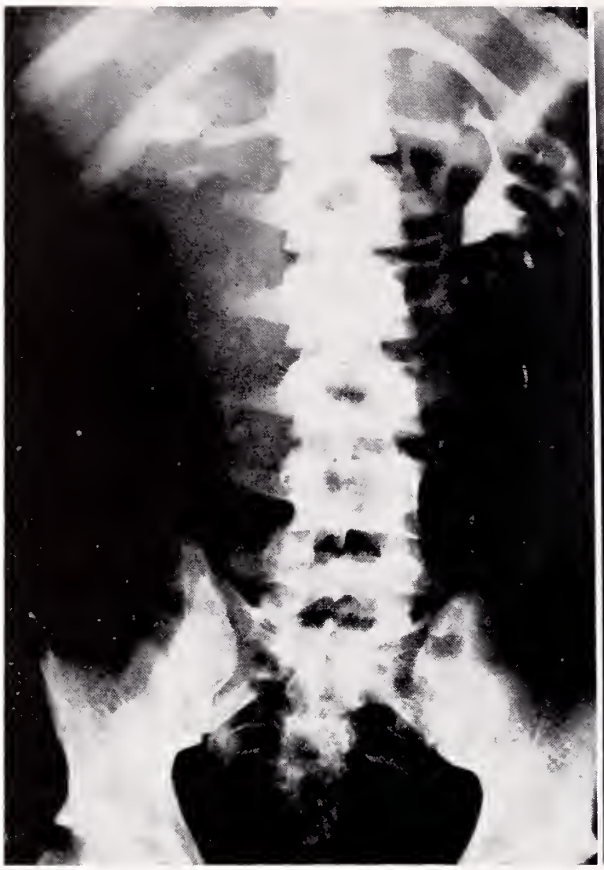

Figure 1a. Renal trauma IVP early film with minimal extravasation.

Figure 1b. Renal Trauma IVP—extravasation more pronounced on 10-hour film.

contusion cases. This consisted mainly of poor calyceal filling or blurring of calyces (Figure 3 a-b). The intravenous pyelogram was abnormal in all cases of laceration or fragmentation. The abnormalities ranged from extravasation as in (Figure 4 a-b) or loss of psoas shadow (Figure 5) or complete nonfunction (Figure 6, Table 3).

Table 3

Results of High Dose Intravenous Pyelography

	Abnormal	*Normal*
Contusion	10	29
Laceration	4	0
Fragmented	4	0*

(* one not performed)

Conservative Treatment

The majority of the cases were treated conservatively. This consisted of hospitalization with absolute bed rest. Vital signs, hemogram, and urinalyses were closely monitored. Most often this was performed in the intensive care unit. The presence of a non-functioning kidney was not seen in an otherwise stable patient in this series. If the hemogram was declining rapidly, the vital signs were indicating progressive hemodynamic deterioration or the flank mass was rapidly expanding, the conserative approaeh was abandoned. In this ease, the avenue of surgieal approach consisted of a transabdominal exploration. Early control of the renal pedicle prior to reflecting the colon and opening the Gerota's fascia was performed. The conservatism of urologic approach directly correlated with the degree of injury. The contusion group had a zero nephrectomy rate and one death which was related to post-traumatic pulmonary insufficiency.

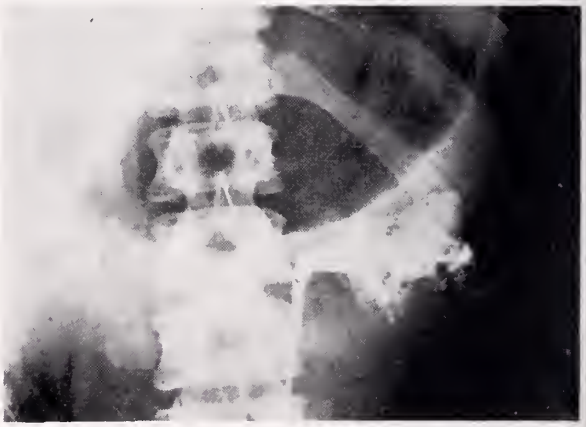

Figure 2. Retrograde pyelogram showing massive extravasation.

Lacerated kidneys required nephrectomy in one out of four cases. In this case, a delayed nephrectomy became necessary due to infection of extravasated urine. Conversely, four of five cases of fragmented kidneys (including the one case of penetrating injury in the series), required nephrectomy. The fifth fragmented kidney was diagnosed postmortem (Table 4).

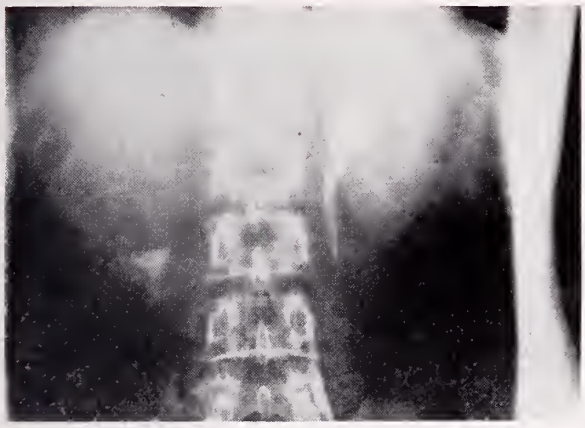

Figure 3a. Contusion of kidney showing poor filling or blurring of calyces.

Figure 3b. Contusion of kidney showing poor filling or blurring of calyces.

Table 4

Management and Results in Renal Injuries

	Operation	*Nephrectomy*	*Deaths*
Contusion	0	0	1*
Laceration	1	1	0
Fragmented	4	4	1**

*Death unrelated to renal injury.
**Non-operative.

Conservatively treated patients were kept at bed rest seven to ten days or until the urine cleared. Significant delayed hemorrhage was not

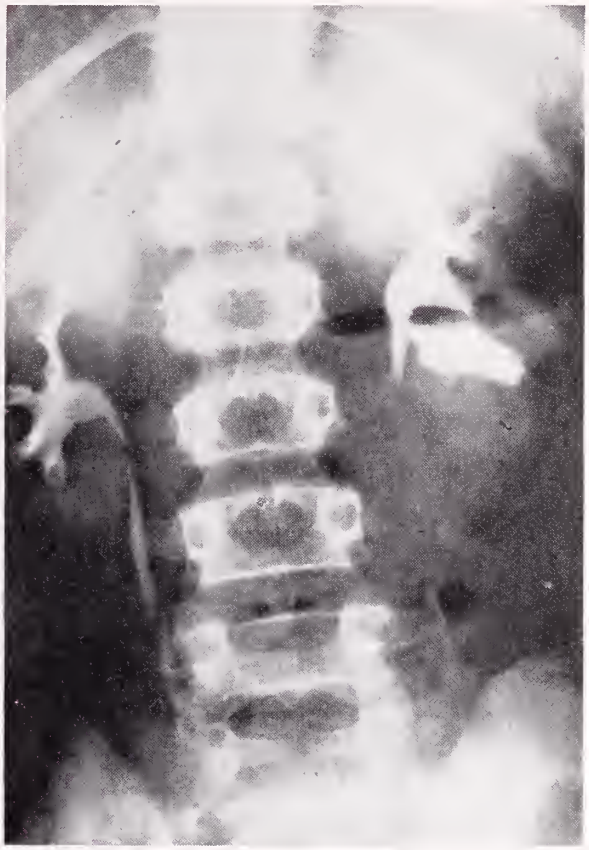

Figure 4a. Lacerated left kidney showing extravasation.

Figure 4b. Lacerated right kidney showing extravasation.

seen in this series. Patients were followed in clinic with particular attention to the development of hypertension. Hypertension was not observed in this group. The only post-traumatic sequel was diminution of the renal parenchyma of a previously contused upper pole(Figure 7 a-b).

Discussion

The presentation of renal injury in most large series was by hematuria and flank tenderness.[2, 3, 4,5] Koontz[5] found hematuria in 98 per cent of his cases. Hematuria does not necessarily correlate with the degree of injury.[4] The best means of assessing renal injury has been the subject of much debate. The intravenous pyelogram which in earlier series had a poor correlation with degrees of injury has been revitalized by increasing the dosage level.[6] More recently, using high dose pyelography, Marrow and Mendez[4] had 87 per cent diagnostic reliability. Mahoney and Persky reported 93 per cent effectiveness by adding nephrotomography to films taken after administration of 120 cubic centimeters of 50 per cent sodium diatrizoate. Others have used dosage up to one cubic centimeter per pound body weight for intravenous pyelography.[7] There are some investigators who recommend radioisotope scanning to evaluate renal trauma.[8,9] More recently the arteriogram has become the tool for evaluating the nonvisualizing kidney on pyelography.[3,10] Some authors have stated that avascularity on arteriogram or scan is a good indication for surgical intervention because it indicates severe parenchymal damage or arterial obstruction.[9] Retrograde pyelography probably should be used only to assess the continuity of renal pelvis and ureter if severance is suspected.[3]

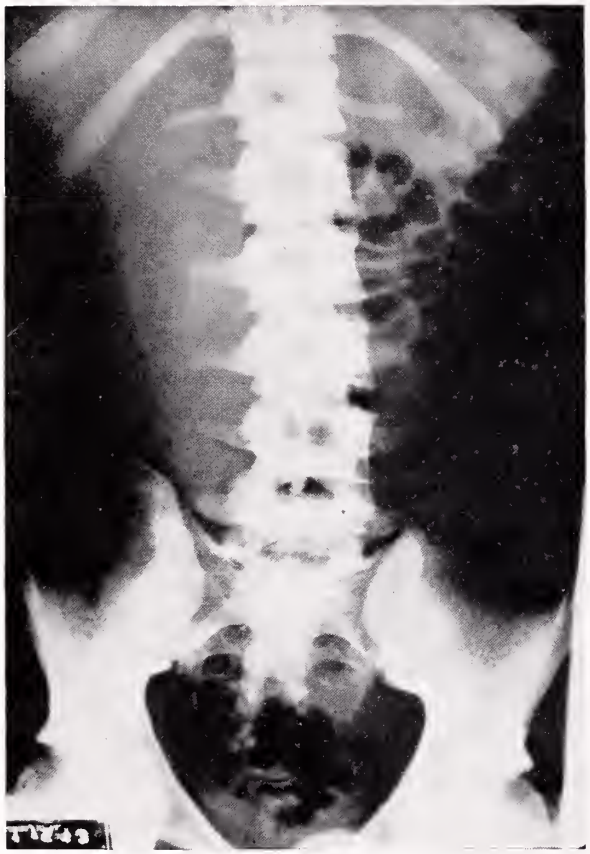

Figure 5. Plain film showing loss of psoas shadow in severe renal injury.

Figure 6. Fragmented kidney showing non function on IVP.

Trend in management of renal trauma presently leans strongly toward conservatism.[1,2,3,4,5,11,13,15] In earlier years, more operative management was performed.[12] In order to enforce conservatism, one must resist the temptation to open the retroperitoneal space to explore or drain hematomas.[11] The non-operative management also extends to lacerated kidneys with extravasation which is not likely to cause serious sequelae. If infection or hypertension or persistent bleeding become a problem, a delayed partial or total nephrectomy may be performed, usually under better conditions.[2] A situation which forces a more aggressive management is penetrating injury. Scott,[14] et. al. found 80 per cent of penetrating renal injuries had associated injuries which required operative treatment. Surprisingly, 29 per cent of Scott's series had no hematuria. There are those who would explore any moderate or severe renal injury early with vascular control and who feel their success rate rivals conservative treatment.[16,17]

Sequelae of post-traumatic injury to a renal unit has been reported as hypertension or occasionally obstruction with hydronephrosis.[18,19] The West Virginia University Hospital series had a 13 per cent nephrectomy rate which compared favorably with most large series.[1,2,3,4,11,20]

Summary

The experience of a five-year period 1967-1972, with renal trauma at West Virginia University Hospital is reviewed. The diagnostic efficiency of high dose intravenous pyelography and the value of conservatism have been brought out in the series. This experience has been compared with and found to be quite similar to other large series of renal trauma patients.

A list of references may be obtained by writing The Journal.

Figure 7a. Contusion of kidney IVP at time of injury.

Figure 7b. Contusion of kidney follow-up film six months later showing diminution of upper pole parenchyma on right.

Have Trouble Telling Right from Left?

Do you sometimes have trouble telling right from left? If so, you're not alone according to a recent article in *Archives of Neurology*.

Many intelligent adults often make a mistake when called on for a quick answer to which is right and which is left. A Los Angeles neurologist recently polled a group of physicians and their spouses on this subject. In the group, 17.5 per cent of 382 women and 8.8 per cent of 408 men said they frequently experienced confusion in right-left orientation.

This confusion occurs often in adults, even of superior intellect, and is much commoner in women, says Sheldon Mark Wolf, M.D., of Los Angeles.

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

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B--RB

Gastroscopy Findings Confirming Diagnosis In Two Unusual Cases

(Mallory-Weiss Syndrome and Gastric Polyposis)

Catalino B. Mendoza, Jr., M. D.; Johannes VanDerBijl, M. D.; Mr. William Richmond, William C. Dressler, M. D.; C. S. Krishna Murthy, M. D; Mansour Jadalizadeh, M. D.; And Raymond C. Bonnabeau, Jr., M. D.

The recent development of a flexible fiberoptic instrument for examining the gastrointestinal tract has added significantly to the clinician's diagnostic armamentarium. Recent advances in its design have rendered the instrument safe in the hands of a well-trained operator.[6]

With the use of the esophagogastroduodenoscope (ACMI Model FO-7089A), 100 consecutive examinations on 87 patients with gastrointestinal symptoms which could not be diagnosed clinically or by roentgenology have been carried out at the Veterans Administration Hospital in Clarksburg, West Virginia. No complications have been encountered.

Two unusual cases from the series are reported.

Case Reports

Case No. 1.—D. B., a 46-year-old white male, was admitted to the hospital on October 5, 1972 with a history of vomiting blood the night before admission. The patient had had a similar episode 15 years earlier which had been diagnosed as peptic ulcer disease and treated conservatively. Past medical history was noncontributory except for chronic alcohol abuse.

Physical examination on admission revealed him to be diaphoretic, with blood pressure 90/60 and pulse 120. The abdomen was soft and normal bowel sounds were present. Liver and spleen were not enlarged. There was localized tenderness in the right upper quadrant of the abdomen. Rectal examination revealed black tarry stools. Hemoglobin was 13.5, hematocrit 40, white blood count 21,000; prothrombin time was normal. Urinalysis, electrolytes and BUN were within normal limits.

A nasogastric tube was passed and drained bright red blood. The patient was treated conservatively with Probanthine I.M. and iced saline irrigation through the nasogastric tube, but this failed to control the bleeding. To maintain an adequate hemoglobin level, the patient required seven units of whole blood during the 24-hour period following admission. A gastroscopy was performed, revealing a bleeding point at the lower esophagus and stomach. No esophageal varices were found. Attempt to control the bleeding with a Sengstaken-Blakemore tube was unsuccessful and it was decided that exploration was necessary.

The patient was taken to the operating room and celiotomy was performed. No duodenal ulcer was found, but there was a laceration of the stomach near the gastro-esophageal junction as well as a submucosal tear of the lower esophagus. These were oversewn with 3-0 chromic catgut sutures and a vagotomy and pyloroplasty were performed (Figure 1). The liver, spleen and other organs were normal. Postoperatively, the patient did very well. Gastroscopy was performed 20 days after surgery and showed good healing of the suture lines. Laboratory studies including 12-hour gastric analysis revealed 0° free acid, total acid 30°. The patient was discharged in good general condition.

Case No. 2.—T. D., a 78-year-old white male, was referred to the Clarksburg VA hospital by his family physician after two upper gastrointestinal series were suspicious of malignancy. He was admitted November 14, 1972. He stated that before seeing his family physician he had noted tarry stools and had vomited coffee-ground material. A cholecystogram 15 years previously had revealed gallstones, but he had been asymptomatic since that time.

The Authors

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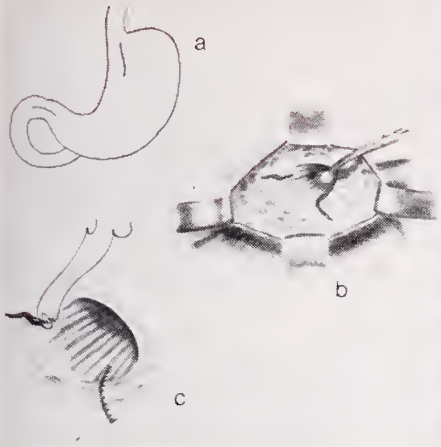

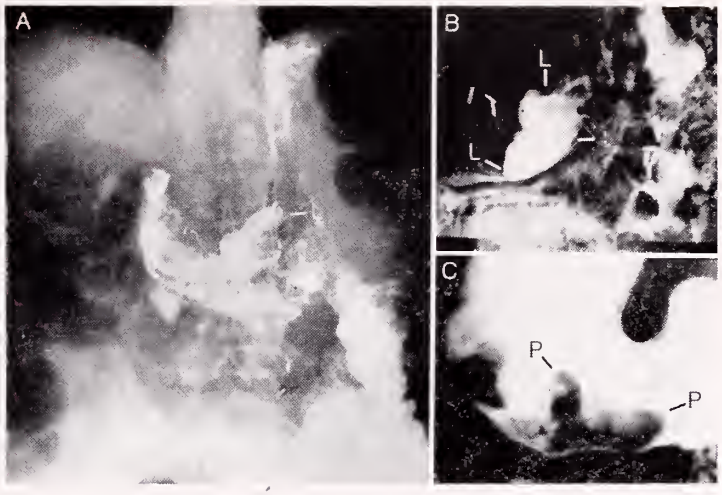

Figure 1 (left). — (A) Diagrammatic sketch of the pylorotomy and gastrotomy incisions; (B) Submucosal tears at the cardio-esophgeal junction; and (C) Continuous 000 chromic catgut suture applied at tears. Figure 2 (right). — (A) Upper gastrointestinal series showing the barium filling double density along the lesser curvature (L); (B) Close-up view showing barium-filled crater (L); and (C) Elongated filling defect close to the greater curvature (P).

Past history revealed a mild heart attack in 1951, but he had been asymptomatic since. He had a history of chronic emphysema for the past eight years.

Physical examination on admission revealed an obese male in no acute distress. Blood pressure was 130/90. Lungs were increased in AP diameter and there was some expiratory wheezing present. There was regular sinus rhythm of the heart, without murmur. Abdomen was nontender, bowel sounds were normal, liver and spleen not palpable. The prostate gland was slightly enlarged.

Upper gastrointestinal series (Figure 2) indicated a small sliding hiatus hernia, a gastric ulcer approximately four centimeters in diameter in the posterior wall, and the suggestion of an ulcer in the duodenal bulb. This was interpreted as a large ulcer, suspected to be penetrating type, and a leak from the ulcer posteriorly. Gastroscopy was performed, revealing multiple polypoid masses throughout the stomach.

The patient continued to have right upper quadrant pain, tenderness and leucocytosis. Urinalysis was normal, VDRL non-reactive. Twelve-hour gastric analysis revealed 0° free acid, total acidity 25°. It was felt that exploratory laparotomy was indicated. He was taken to the operating room on November 27 and gastrotomy and pyloroplasty was performed. No ulcer was found but there were numerous polyps which extended to the cardia. Two of the larger polyps, approximately two centimeters in diameter, were excised. Histological section showed no malignancy. The gallbladder was inflamed and 16 gallstones, one-half to one centimeter in diameter, were removed. Because of the patient's precarious condition, a cholecystostomy tube was placed in the gallbladder and the procedure was terminated.

Postoperatively, the patient had a rather stormy course due to the chronic lung disease. He responded to IPPB treatment, however, and by the time of discharge the dyspnea was less and his lung condition had improved. A T-tube cholangiogram through the cholecystostomy tube showed normal biliary channels and no retained stones.

Discussion

In this study, 87 patients with upper gastrointestinal symptoms underwent gastroscopy examination. One case of Mallory-Weiss syndrome, caused by vomiting after excessive alcoholic intake, was encountered. The etiology of this syndrome has been previously described.[4] Gastroscopy revealed massive hemorrhage at the cardio-esophageal junction. Podgorny[3] had utilized a Sengstaken-Blakemore tube to control bleeding of this type. In our case, however, the tube failed to control the bleeding. Suture and ligation of the tear in the stomach and esophagus corrected the hemorrhage.[2] Other reports[8] have described the successful use of vasopressors for this condition.

One patient whose x-ray studies indicated ulcer of the stomach was found on gastroscopy to have multiple polyps, with no evidence of ulcer. Because of roentgenologic findings of possible extravasation of contrast media outside the stomach, a laparotomy was performed which

confirmed the diagnosis of gastric polyposis, in addition to acute cholecystitis. Because the patient's condition at the time of surgery was rather precarious, it was elected only to biopsy the lesion.

Some investigators have described gastric polyposis as a pre-malignant lesion and have advocated partial gastrectomy,[5, 7] while others have recommended total gastrectomy.[1] In this series of 87 patients, gastroscopy has been found of value as a diagnostic tool and as a follow-up method for patients with gastric polyps, as suggested by other reports.[9] When polyps are less than one centimeter in diameter and are proven on biopsy to be benign, we feel that the patient should be followed with periodic gastroscopic examination. If there is any change in the condition, or if biopsy has indicated malignancy, then gastric resection is felt to be indicated.

A list of references may be obtained by writing The Journal.

If you
don't do it,
it won't
get done.

GIVE THE UNITED WAY

Family Politics And Psychiatric Hospitalization

Donald C. Carter, M. D.

THE purpose of this paper is to express with clarity various reasons for psychiatric hospitalization, both from the standpoint of a family's inner political needs and the hospital's concept of what sort of work they are to do.

Two factors militate discussion of this subject: (1) The high Against Medical Advice type discharges from psychiatry wards of general hospitals and (2) Treatment is often experienced by the patient as suppressive, allowing for retrograde distortion of its bizarre aspects while the good features are just not remembered.

Unsatisfactory psychiatric hospitalization results when the real purposes and needs of the patient and family are ignored or overlooked. It may be surprising to offer the thesis that psychiatric hospitalization has any purpose or reason other than to stamp out mental illness, but my observations lead me to believe mental illness is at best a 50 per cent reason. Of course, no one without mental illness is ever admitted, but many more severe cases of mental illness are not admitted. Why? Subtle political factors and indirect negotiating maneuvers are just as important as the need for medical care. In the majority of cases these are more important in the long run, especially when the disease components don't resolve themselves. The patient and family have to continue to live together, and most don't go through life thinking of themselves as sick.

Not only is family therapy proving itself applicable to cause and recovery processes in illness, but also it is useful to facilitate some decent level of tolerance of disorder and containment of sick functioning. Political maneuvering in the family ego envelope is then a way to live with an otherwise unlivable set of symptoms.

As a beginning discussion on this difficult subject, difficult because it is so liable to distorted understanding, I believe that the descriptive psychiatric model of Kraepelin can be used better than other models now popular.

My thesis is that many of the major diagnostic categories of DSM II have a characteristic set of social and political problems in which, when these are decompensated, the patient will surface in a medical facility presenting mainly for admission. The disease entity often has existed before for quite some time. For the purposes of brevity and clarity, certain generalizations will be made in this paper which the author recognizes are not always so simple.

The Author

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Neuroses

At the time admission is considered, the symptoms are acutely worsened and communication has broken down. Alienation is here mainly in the communicative field of family functioning. People with neuroses often have difficulty giving us the chronological developments of their symptoms. This is because of the chronic, recurrent, but low grade nature of their suffering. When actual hardship occurs their suffering isn't as crippling as one would expect if causes of the suffering are environmental, as neurotic people like to allege. When things are going well for the rest of the family they are more inclined to be symptomatic. They seem to interpret the family doing its own thing as neglect of their needs. Neurotic symptoms are neurotic communicative devices used when other methods of communication aren't available to them. Lack of extra receptive tuning on the part of the family to these signals sent, then no response given in turn, is interpreted as communicating a fact of no personal worth. Their families don't really feel that the patient is worthless but, by this sequence, are manipulated into expressing it.

I would expect the family not to want or see any real need for the hospitalization of a neurosis. From their experience and viewpoint, I believe this is valid. If the patient can get himself admitted, he wins a silent argument. The patient knows quite well the family's point of view, so he doesn't seem to cooperate in coming in to intensive care early which, in our opinion, would prevent serious symptom development. He must bridge this conflict by one of two political maneuvers. Most often he attempts or

threatens suicide, not by serious means, or he develops a withdrawal of interest and investment in the biologic aspects of family life, which could just as well be interpreted as a physical illness. He then is unable to give interpersonally; the family's dependency needs go unmet; and the family considers a renovative job on a psychiatric ward. Renovating the old pattern of neurotic catering to regressed selfish needs of others without overt hostility or confrontation so characteristic of the impaired life style of the premorbid neurotic person is their goal, thought through to this conclusion after being forced to agree to the admission.

Covert reasons then for hospitalization are quite different in the three groups involved.

First, the neurotic and his doctor want him in to begin communicating better.

Second, the family wants him in to restore old compensated modes of neurotic living. These modes have worn down due to their no longer rewarding the patient in a compensatory way. The family had assumed they could safely ignore the patient's needs and devote themselves to their own narcissistic pursuits.

Third, the hospital may over-identify with the physical illness components of the patient's situation and overtreat this single aspect of the total alienation problem. In fact, whatever emphasis the hospital treatment program has, it will alienate one of the other two parties if it uses that theory and method exclusively. Hospital staff seem to be terribly afraid of being manipulated by patients. Manipulativeness is a symptom in neuroses and character neuroses. If the hospital staff is afraid of a symptom, they naturally "treat" it by massive suppressive devices. Its political utility is ignored, but the family intuitively values it and allows some reinforcement of it.

So, in a symptom suppressive milieu the family's sympathy will need to be ignored, and the family's objective to restore the neurotic life style will also be seen as bad. This ignoring process is not appreciated by the family, and they resent it later when they are not under the authority of the hospital. Small wonder no one learned something from such an encounter.

Learning to improve such maneuvers that could be used later to correct beginning spirals of alienation in the family and, thereby, avoid subsequent hospitalizations is a hospital teaching function for the family involved. The foregoing comments are based on the theory that a person with a neurosis will function better if he is not separated from his family, and this is at two levels—physically and ego-envelope-wise. I believe his family is designed by nature to provide continued infusions of ego strength.

Only when the interactions have become progressively alienating is separation (hospitalization) called for, and then the real object of treatment should be the alienating processes, not a person *per se*. Of course, severe levels of symptoms in a person are themselves alienating processes and can be suppressed by strong measures to the total benefit of the family. Each family will need titrating of its symptoms because they are signaling communication devices. Only under certain contingencies, i.e., great severity or a very abnormal response to them are they to be seen as malignancies to be totally eradicated. Ambitious treatment programs to change these communication systems completely extend the purpose of hospitalization too far and again insure ultimate failure. Such a change is a long-term outpatient therapy project.

Schizophrenia

Here the problem extends far beyond a communicative defect in the patient. Hospitalization is sought by the family due to alienation. In neurosis the symptom carrier is the one who feels as if he is alienated. In schizophrenia the patient often denies any problems and is symptomatic in lieu of performing a certain autonomy of living when he has been pressed to perform. But the lack of certain functioning of his personality, i.e., reality testing, is gross and cannot be denied by the family any longer. Further, they would go on coexisting with it if they could, but some important family member is personally disturbed by the symptoms and has tried to work with the defective person. He has, of course, failed and is angry, hurt, and confronted in a manner he can't deny. They bring him in hoping a medical model treatment scheme will eradicate the symptoms. The family knows that psychotic symptoms are like an open festered wound, drawing all personality vitality into itself. They are on the side of the physician in hoping for a quick treatment of the patient and his symptom removal.

Meantime, the patient has simplistic and unreal ideas of why he is there and what is to be done. He blames his family. They are in some small part to blame, but not totally. They are really the best friends he has when more facts are known. He would leave the hospital prematurely if given half an opportunity.

The hospital has several tasks to be done if an unsatisfactory result, politically speaking, is

to be avoided. The seriously sick person needs a new ego envelope within which to function. His family has withdrawn his vested rights in their protective—nurturant—suppressive system for their own reasons. Their own reasons will need to be dealt with by hospital staff so that a restoration can occur, patient to his family, returned at a time when his symptoms are titrated down to a level below the toleration threshold of the family, perhaps more specifically, the key family member involved with them.

The hospital must not pass adverse judgment on patient or family but treat the alienation existing within their family system so that the particular family can be helped to function decently. The most common mistake hospital staffs make is to overtreat the symptoms, devitalize the patient, then cast him off into unrelatedness. The second most common mistake, often made concommitant to the first, is to conclude that the family caused the patient to be sick, separate him from them in an attempt to stop the cause-effect sequence, and then not offer him a personality envelope in which he can function. Everybody looses on that one—small wonder they wouldn't want to continue treatment.

The above comments in family politics and schizophrenia are oriented to the theory that a person with this illness has certain ego functions which don't function without continuous infusions of family support, and separation from this support is disastrous for him. Hospital personnel often erroneously assume he will be cured by separation from family. Long-term benefits are obtained by the infusion of a professional person's meditative skill into the families functioning. Outpatient follow-up is the best arrangement once the family gets the idea.

Manic Depressive Disorder

Hospitalization in this disease is again a family idea or, rather, a family solution. The family often is too inadequate to force the issue. For mania they seek to get the physician to control him but ask for help behind the back of the patient, fearing his anger. In depression they often show inertia and hesitate to implement orders. The family can't stand up to him so they ask the hospital to do it for them. If he becomes angry at the hospital staff, the family may play a back-biting game and sabotage everybody. Then they are unhappy that the hospital didn't control him as he signs out AMA.

The hospital has to titrate his mood rapidly as painlessly as possible in mania and with much real support in depression, all without loosing rapport with patient and family. Family will withdraw him if he comes down precipitously (they know that's very painful) or if he gets angry at them for his being suppressed by treatment. Another reason for withdrawal by family will be their own dependency needs are being unmet as a result of his being in the hospital. This occurs regardless of the severity of the illness. They are characteristically very dependent on him but don't express it openly. The whole family ego envelope functions best when his mood is precisely in between depression and elation. They all look normal at those times.

The primary purpose of medical care is then to use the family system to report early deviances in mood so that the professional person can help the family system correct the spiraling process up or down, as the case might be. As in all psychoses, the family's natural symptom suppressing systems of reaction are alienating and, thereby, produce worsening of the symptoms themselves. Professionals must insert themselves into the family corrective system to make it work properly. Hospitalization is a titration process of the patient's mood, and an educational supportive venture to the family, and both must be done in a supportive manner for each to get what they want. Some professional person from the hospital experience must follow the family for quite some time after discharge to insure its goal of ameliorating the overall course of the illness.

Involutional Melancholia

Families bring in these patients and are often silent about the struggles which led up to the first appointment. But, if their sense of futile desperation isn't treated and the very defeating process of catering to the ambivalent demands of the patient isn't stopped, the hospitalization will be refused or will be very brief.

Politically these patients have occupied an important power position in the family, like the manic patient does in his family. But they are not getting what they need from their families, and it's hard to tell when the breakdown of mutuality occured. Ambivalence here is paralytic. If the hospital doesn't quickly join hands with the faltering family and forcefully insist on strenuous treatment, often refusing the pleas of the patient when he is phasing into a withdrawal aspect of his dual ambivalent attitude toward the hospital, then he will go out AMA, partially treated.

Vigorous attempts should be made to get several family members present upon admission, then a day or two later into a conference decid-

ing on the treatment. This is the best way to stop the see-saw and get a restoration process going.

The Paranoid Patient

The political features of psychiatric hospitalization of paranoid persons are undergoing change. Formerly a person who had paranoid thinking could be presented to a physician or court and, on the basis of his distorted percepts, be forced to accept hospitalization. His stay in the hospital treated the symptom suppressively, of course. Although this is only the end product of an alienation turn of political events, it has some contemporary use as evidenced by the singular fact that even continued care psychiatric hospitals don't seem to keep this sort of patient long.

I believe his general vitality makes it easier for staff to wish for, therefore to believe, that he has recovered his reason. His general good vitality or self confidence makes him seem promising, so favorable illusions can grow rapidly around him. When the staff discover he has more stick-to-itiveness and stamina than they have, they may give up the strong repressive measures designed to stamp out his errant reasoning and rationalize that he isn't threatening anymore, just harmless eccentricity to be overlooked. This is likely to follow a series of treatments which de-energize him so he looks better.

But his family resonates to his plea for them to remove him when they discover him de-energized by the treatment, i.e., Thorazine. They often sign him out quietly against medical advice. Again at home they tacitly allow him to stop his chemotherapeutic suppression and, for a while, enjoy his rising spiritedness. During this phase patient and family are sure all is now well and will forever be all right.

Two Phases of Importance

Paranoid perceptions and distorted unreasonable thought concepts are political facts of life that these families try to live with. It occurs to me that two phases are important for us to know about, if we are to find out the real and actual reasons families bring their paranoid ones in for admission and how they manage to get on with them outside the hospital.

The first phase has to do with a paranoid person getting sick. We are all agreed his problem is relative lack of reality testing, one of the ego functions, especially when he gets overly energized. Political factors which help him in every day family life are the use by others of his sureness of opinion, his natural self confidence, his boldness in expressing anger, and his easy assumption of responsibility. This latter part he may do with greater or lesser philosophizing, a faculty which other family members are likely to be weak in doing. He is a natural leader of the family then, at least in some ways. His closed sort of perceiving and his vigor in imposing his way on others tend to produce complimentary, nervous, doubting, shaky opinions; timidity; and deference to him in making decisions.

When he starts the skid into absurdity, the family needs to be quite close to him to loan him the ego function he is short on: reality testing. He may be found pushing them away if they offer the loan in any way that could change the original family political arrangement. It may seem logical to them that dumping him as a formerly respected family member is a suitable political reform, for him failing them in his role. But he can function fairly well if the loan of the ego function is maintained. The loan is actually an unconditional infusion of support, without strings attached, but for it to be helpful to him, no family member can be confronting in this maneuver, i.e., perceiving it as one way.

Such a confrontation ruins the utility of the gift for him. So far in this process it's all an intrinsic family matter, and it will work when important others stay close, empathic, supportive and flexibly reciprocal. Outsiders and outside influences, i.e., a separating adolescent offspring, can disrupt it, by focusing only on the paranoid one. Such an outsider may think the paranoid one is getting the most of the deal, exploitatively speaking. That's a near-sighted view. The other family members get a lot, although they pay a price of always remaining locked into a system. As they mature, however, they can leave it if at least one remains in the system.

If the family hospitalized him reluctantly in only a partial alienated state, they really hope he will return to them and play his role with them more decently. The staff of the hospital needs to seize upon the admission conferences with the family to get the alienation spiral reversed. We serve best if we titrate down his excessively aroused affective state to near normal levels, and this produces dramatic improvement in the absurdity component of his dealings with the family. Then they can live with him again with their sort of mutuality. Excessively lowering his vitality to a bland level really makes reinstatement of his role in the family impossible.

Now, for the second phase, let us look at the family politics of a bad hospitalization of a paranoid patient. We pick it up at the point where the hospital staff has reduced him to a well phenothiazinized, compliant, sleepy, shadow of his old self. They refuse to recognize his needs for an ego loan when his energy comes up. They, of course, have no need for his natural personality attributes, which are so much depended upon by his family. It follows then that, being bored with him as he is with them, the staff dumps him back on the family after relabeling him, psychosis recovered.

The family needs his vitality and, of course, are smart enough to see that continued drug ingestion is devitalizing him. They look the other way as he stops ingestion. For a few days the drug residual in his tissues accidentally has him more fairly titrated. They all assumed that he was cured, that the hospital treatment was worse than the original disease problem, and that the hospitalization was generally a mistake. It made him sick (feel devitalized into loss of self-confidence). They know only too well what a problem it is to struggle along in this world with low self-confidence. A new bond of quasidelusional thought is shared and validated. Externalization of the thought disorder occurs. Before it was only an internal family matter. Now it's the family against those who would help by chemotherapy.

General isolation of the family occurs, and the more healthy members must split their loyalties and opinions in order to live in the two separate worlds. For us in the mental health care delivery world, we have lost the opportunity to go on helping quite simply because our psychiatric hospitalization care program couldn't be individualized to the family's political needs. We tried to put our political needs first.

Again, one can see the ultimate goal is for the mental health care professional to enter into the family political system as a therapist working to add his skill to the betterment of that system.

The Psychophysiologic Reactions

The most difficult to hospitalize psychiatrically of all patients are these. As a group they don't want anything to do with psychiatry. Yet they often overwhelm the family physician's repertoire of care and often get quite threatening and demanding. They are continually communicating on a different wave length from that which the medical profession is receiving. The family is tuned in on another set also.

The patient wants two things basically and one thing superficially from the medical profession. This latter is a relaxation from the tensed up and limbic system arousal state of alarm, which is expressed in the vulnerable and symptomatically pained organ which is complained of as if it were diseased and at fault. Half hidden behind this vigorous complaining are two personality features—explosive hostility and craven dependency traits. These are basically ego syntonic to him, but he is often driven to repudiate one or both in his submitting to family political forces, and he may even have come to believe he has extinguished these traits in himself.

The psychiatric hospital staff doesn't seem to realize that his purpose in being there is to relax. They fear that if he is allowed quiet rest and sedation he will become permanently dependent on the hospital and never leave, so they read out the hostility and dependency as symptomatic objects of hospital extermination. He may join in, consciously agreeing with them in a superficial and social sense. If so, his symptoms will worsen because that's what happened in the family political situation before he got sick. Also he doesn't want staff to bring that up. He construes their pointing it out to him as their telling him he is a psychotic. That maneuver is designed to get him off his personality trait problems. He has no real motivation toward or hope of changing these, and he is trying to get the world to adapt to him, not him to it.

The family hopes to get him treated to rid him of hostility, dependency and his painfully dysfunctioning organ. They think he can then return to them and support them in the pretended indulgent way he seems to have tried earlier when he decided to renounce his own hostile demanding ways. Shortly thereafter his tension and symptoms started.

He and his family must rejoin the personality envelope system of giving him a lot of dependency gratification as well as quick respectful obedience, so he won't have to get mad to be respected (and feared). In their doing so, he will function for them as a happy well person. They will need several supportive counseling sessions to work through their hidden resentment at his manipulative (though consciously unintentional) use of a malfunctioning body organ to dominate the family politics.

Hospitalization is used then primarily for relaxation of tension, not activation of underlying pathological character traits in conflict with the family. That latter task is too big a job for the hospital. It can be done on a long-term outpatient basis if the initial rapport of hospitalization is used to restore the system of patient and family interdependence.

Character Neuroses

These common and troublesome syndromes will be discussed here as covering the general principles involved. Hysterical personality, homosexuality and drug abuse are types of character neuroses which repeatedly surface in troubled political waters.

Hysterical Personality

In hysterical personality the patient's goal is to maintain a central connectedness with his family, in order to bask in attention and approbation. He seeks to avoid competitiveness, hostility from certain others, responsibility, independence, and separation from people he controls and manipulates through his special communication system which others outside the system call sickness. Often he meets these conditions through one or another of two preoccupations on the part of a spouse. The spouse may have erotic type envy and jealously, constantly worrying about or checking on the marital fidelity of the patient. The seductive nature of all requests he makes is a good priming source for this preoccupation. Therefore, attention is never wanting, even though they may be geographically apart.

The second one is constant worry of the important other person. That the patient has some illness, something wrong with the body, which incidentally is highly invested as an object of central concern, scatters the mind of the patient and the connected person, and they run to physicians and hospital emergency rooms a lot. They look and act so anxious and disorganized at these times that the whole system is reinforced by staff who, neurotically fearful of missing some serious illness, admit them. Ward personnel not sharing the neurotic concerns see a healthy vital person and they know there is no illness there. Manipulative and attention seeking behavior alienate staff rapidly.

All of this means the psychiatric hospital is not really an optimal therapy milieu for this syndrome. Massive suppressive treatment routines are attention of a sort, but are hardly a sign of approbation and unconditional indulgent approval. These patients cannot in good conscience cooperate with such ward programs, and they will seek attention of a more flattering sort elsewhere. It isn't that they don't want help. It's just that the definition of help is totally different from patient, staff, and family points of view. Adequate care starts from the beginning to bring patient and family back together again in their own natural system and to play down any psychiatric labeling, controls, or cop-outs. If admission is absolutely necessary it should be for one day only, time to get the folks back together again. Daily outpatient family conferences can then replace hospitalization.

Homosexuality is sometimes offered as a chief complaint and psychiatric hospitalization carried out, but the real reason for the hospitalization is simply not the sexual problems of patients. Depression, panic, anxiety, legal concerns are among the real reasons. These may be accompanied by intense fear and running away to a hospital for protection, but the changing of the character trait is not the purpose of hospitalization and no one should pretend it is. The generally suppressive treatment programs of psychiatric wards, carried out in the attack on psychotic and neurotic symptoms, are very much out of place in the treatment of character traits. They just don't work and are experienced as a personal attack by the patient. He must leave by any means he can arrange, most often lying his way past the keepers of the keys. Family conferences and early discharge for outpatient care is the only honest thing to do.

Drug abusive syndromes are hospitalized on psychiatric wards and are another example of trying a general suppressive treatment on a character trait problem. The patient may be alienated, homeless, regressed, confused, friendless, and malnourished, but he isn't psychiatrically ill in a neurotic or psychotic sense. He wants immediate regulation of his drug ingestion. His family wants this, and the trait disorder eradicated. The hospital wants to help but not be used as a patsy or a free motel. Pretense to get desired goals is the order of the day. The hospital staff pretends to cure him. The patient pretends to be cured in order to get back into everyone's good graces. The family pretends to have "faith" in hospital and patient, "trusting" him so he will then somehow have "faith" in himself, which somehow is to keep him from further drug ingestion. In this political shuffle everybody seems to win, but only for a few days. Then anyone who still looks on knows it's a game of all losers. A much more honest approach is a broadly based outpatient facility using multiple systems approach. Renovation of him physically and socially is a legitimate hospital goal. Withdrawal of drug safely is another, but let's not pretend what we do in a hospital program for this type of problem will last if no active follow-up is maintained.

Marital problems and adjustment reactions of all age groups are examples of a general diagnostic group which can be harmed by psychiatric

hospitalization that uses a one-patient, symptom suppression, treatment program. The presenting person, not even with his symptoms, simply isn't the total sick entity to be treated if the problems are really to be resolved. Family therapy still has a long way to go to be accepted either by the mental healing professionals or the general public, but it is this diagnostic group that can bring quick and good results. Of course, marital and adjustment problems can be secondary to neuroses, psychoses, and character trait disorders, but often they are not and, when not, shouldn't be over-treated as such. Perhaps psychiatric hospitalization in these cases is best used as a meeting place for all to get together and plan total care.

Differentiated Treatment Programs

This article is then a plea for psychiatric hospitals to develop differentiated treatment programs. This would include refusing admission to certain families who are trying to hospitalize for unrealistic motives. Each hospital would need an associated outpatient care facility which could operate on hours of availability more similar to hospital ward care.

The political motivation of each of the three parties involved must be taken into consideration in addition to the illnesses themselves, if maximal hospital benefit from psychiatric hospitalization is to be assured. Even though this motivation is just beginning to be understood it must not be ignored or denied any more. It contains such things as aggressive power plays, dependency strivings, dominance-submission roles, manipulative controlling maneuvers, evasion of responsibilities and decision making, prevention of separation of symbiotic pairs, just to name a few on a much bigger list. Because these things are really family affairs, psychiatric care, even at the hospital level, must be a family care process.

This paper omits the family politics of the boderline state patient. This is the sole diagnostic type that does well in a repressive structure treatment milieu. Its politics on the other type psychiatric wards are being dealt with in many good current articles elsewhere.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

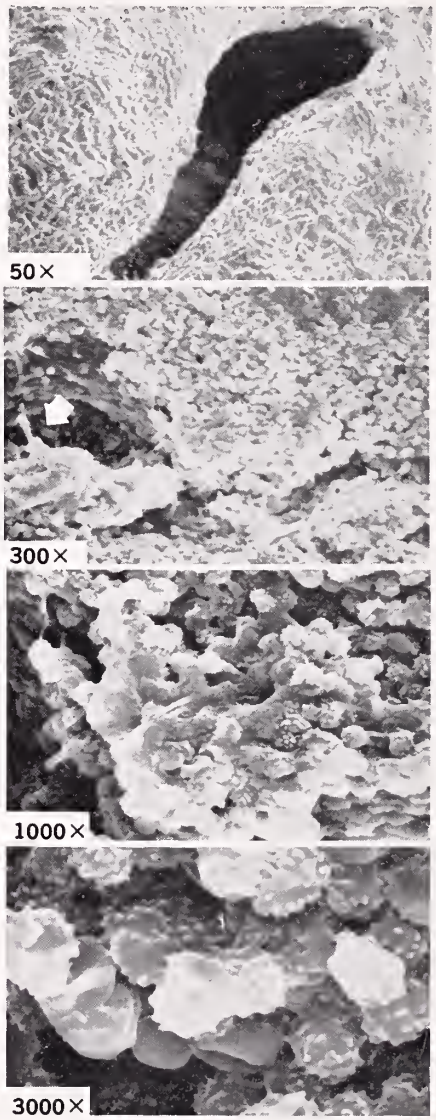
All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Progress i

Diagnosis

In these illustrations of tissue from a patient with acute cystitis, you can see the swollen and inflamed mucosa of the ureteral orifice (50×), a fibrin strand (300×), and a whitish exudate composed of polymorphonuclear leukocytes (1000× and 3000×). The photographs were taken with the scanning electron microscope (SEM) by Dr. Shirley Siew, Associate Professor of Pathology at the University of Pittsburgh School of Medicine. They come from the clinical exhibit "Scanning Electron Microscopy of Urinary Tract Infection," which won first prize in Clinical Research at the May 1972 meeting of the American Urological Association.

The scanning electron microscope promises to be extremely useful in its investigation of human pathology. In time, examination of tissue with the SEM is likely to play a significant role in the diagnosis of urinary tract infection.



A note on the photography: These photographs were made by ning electron microscope, which transmission electron microscope on the basic principle of exposur to a beam of electrons in a vacuu the SEM, electrons bombard the of tissue which has been given a ing of gold. The electrons reflect tissue onto a television screen, a resulting photograph shows a thr sional effect. The tissue sections be ultrathin, so there is a minimu handling and distortion.

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References: **1.** Bran, J. L.; Karl, D. M., and Kaye, D.: *Clin. Pharmacol. Ther., 12*:525, 1971. **2.** Burke, E. C., and Stickler, G. B.: *Mayo Clin. Proc., 44*:318, 1969. **3.** Hibbard, L. T., in Bulger, M. J., *et al.: Patient Care, 1*:(3) 47, 1967. **4.** Holloway, W. J.; Furlong, J. H., and Scott, E. G.: *J. Urol., 102*:249, 1969. **5.** House, T. E., *et al.: Obstet. Gynecol., 34*:670, 1969. **6.** Lampe, W. T.: *J. Am. Geriatr. Soc., 16*:798, 1968. **7.** Moffat, N. A., and Wenzel, F. J.: *Curr. Ther. Res., 13*:286, 1971. **8.** Normand, I. C. S.: *Practitioner, 204*:91, 1970. **9.** Pryles, C. V.: *Med. Clin. North Am., 54*:1077, 1970. **10.** Seneca, H.; Peer, P., and Warren, B.: *J. Urol.*, 99:337, 1968. **11.** Trafton, H. M., and Lind, H. E.: *J. Urol., 101*:392, 1969. **12.** Cohen, M.: *Pediatrics, 50*:271, 1972.

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Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms. **IMPORTANT NOTE:** ***In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections.** Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations r

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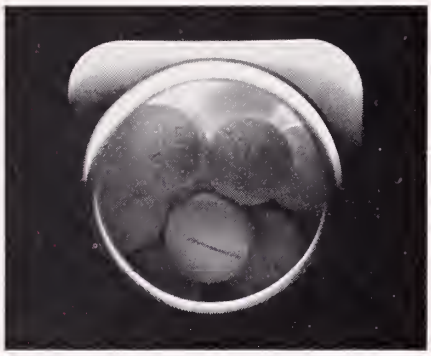

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Special Article

The Health Care Scene: Nursing's Dilemma*

Lorita D. Jenab, Ed. D.

THERE is a broad agreement among us, certainly, that our American health system is truly paradoxical. We have unlimited capacity for excellence in health care coupled with instances of abysmal neglect and inhumane treatment. The sophistication of biomedical science is unprecedented; it has advanced further in the last 30 years than in all prior history. But these remarkable advances have been in acquiring knowledge, skills and resources necessary for the specific diagnosis and treatment of manifest illnesses and we know it is inadequate to the task of delivering personalized comprehensive health care to all people.

There is not a single reason for the dilemma. We cannot place blame for this state of affairs on any single profession or group. The present state is untenable for medicine, nursing and all health groups alike — and it is intolerable for the consumer of health services most of all. This state of incomplete, fragmented care is the result of a combination of multiple societal trends that have produced a massive problem. We all could name these causative factors. Some are:

(1) Increasing affluence coupled with dire poverty resulting in: (a) Some using health services for discretionary and cosmetic care; while (b) Others are excluded from entrance to essential services.

(2) The developing national ethos that health is a *right*, not a privilege.

(3) The technological "boom" and concomitant specialization widening the gap between scientific and humanistic phenomena.

(4) The health insurance industry patterned to support illness care rather than health maintenance.

And so, the social scene in the decade of the 70's is one marked not only by an articulated cry for the availability of traditional medical services into the impoverished pockets of society; but also an unarticulated cry for high level wellness for all.

The Author

- **Lorita D. Jenab, Ed. D., Dean, School of Nursing, West Virginia University Medical Center, Morgantown.**

As we work toward closing the agenda of treatment of illness for all, including those in the ghettoes and the isolated rural settings, let us increase our consciousness of a demand of equal, if not greater, significance: this unarticulated cry of a whole new proportion: "Not only cure my illness, but keep me healthy," — "Not only save my life, but please! help make it livable." The long proclaimed ideal of health promotion-maintenance, and disease prevention now confronts us with wholly different dimensions of service and responsibility.

Let us be done with any attempt at rationalizing our inadequacies and of defending our respective professional territorial rights, and get on with cooperative planning and collaborative efforts for the building of a personalized, comprehensive health delivery system to replace the piecemeal, fragmented, and unnecessarily expensive crises care. A comprehensive, personalized health (not illness) system requires a redefinition of the roles and inter-relationships of both health professionals and institutions in terms of their actual and potential impact upon the family, its home environment, and the entire community, as well as individual patients.[1] A unilateral role shift by any one profession for such a complex problem is no solution. When so much of what has to be done is interprofessional, the redefinition and extending of roles will have to be done jointly.

The harassed physician today is so overburdened with employing his unique skill in diagnosis and treatment of illness he must often be frustrated because he cannot adequately address the complex and inter-active socio-psychologic, the financial, cultural and interpersonal factors

*Presented during the 21st Annual Meeting of the West Virginia Chapter, American Academy of Family Physicians, April 6-8, 1973, at the Lakeview Inn and Country Club, Morgantown.

which contribute to illness and interfere with the consumer getting into the care system.

Most would agree, I think, it is simply not feasible for medicine to maintain this breadth of interest and skill while pursuing and refining a specialization of man's pathological state. And yet the physician would welcome sensitive, knowledgable colleagues to complement his unique skills. In fact, he is searching for them—evidence the proliferation of health occupation groups.

But the proliferation of such a variety of health professionals and auxiliary personnel is in large part a symptom of both medicine's and nursing's inability to define their individual and congruent roles, to respect each others competencies, or to deliver an acceptable level of care. The present crisis in health care is increasingly compounded by the proliferation of health workers with varying levels of preparation, coupled with the complex question of their certification and licensure.

When we, as former Surgeon General Stewart has said: ". . . are no longer able to define the practice of medicine or the practice of nursing"[2] how can we know what types of auxiliary personnel are needed and how they are to be prepared and utilized? Clearly, the present crisis in health care delivery makes multi-disciplinary problem solving a necessity.

The Nursing Scene

Nursing is no less paradoxical than the health scene in general. We cry "shortage" when there is an oversupply from the classical economists view of supply and demand.[3]

As a whole, nursing has increased in overall numbers, and unlike the other health manpower areas, nursing's growth has actually exceeded the growth in population as a whole.

But while nurses have been prepared in numbers abundant, the career withdrawal rate is alarming.

Forty-nine percent of the total supply of nurses is inactive! Of the remainder, more than one out of four practice on a part-time basis. Granted that a profession composed largely of women will have different working patterns than those of men, but nursing has a higher percentage of career "withdrawal" than other women's groups with similar education and training. The problem of career withdrawals of nurses is compounded by the high turnover rate of those remaining active in nursing.

The annual rate of turnover of staff nurses is slightly more than 70 per cent. In urban settings where job change is easier due to number of choices, the turnover rate of nurses sometimes reaches 150-200 per cent. Contrast this with the turnover rate of public school teachers, most of whom are women from the same social and economic groups as nurses. The annual rate of turnover of public school teachers is approximately 20 per cent.[4] We must ask why is this?

Career withdrawals and excessively high turnover rate in nursing is, we believe, due largely to the fact that nursing was shaped in the 20th century by the apprentice system as an arm of administration rather than clinical practice.

Many studies indicate that nurses spend 50 to 75 per cent of their time in non-nursing functions and this proves to be a major source of dissatisfaction. The graduates of four year college and university programs are both underutilized and overutilized. They are prepared as nurse practitioners but for the want of a career perspective—for increased incentive for providing care they are lured into positions of administrative and educational leadership positions for which they are not prepared. When they work as staff nurses, they are socialized into the task-centered role dictated by agency policies which allows too little opportunity and support for true patient-centered care.

Both underutilization and overutilization gives rise to heightening frustrations, frequent job turnover, and finally career withdrawal.

For years now, particularly since World War II, nurses have been steadily increasing their non-care functions while reducing their direct patient contact time. The mounting evidence clearly points to the fact our care system is not working properly and the demand for change is spreading.

We have a growing body of evidence to attest to the capacity of nurses to function at much higher levels of competence in practice — to the benefit of patients and families, medical colleagues and nurses themselves.

Where modifications in the role of the nurse practitioners have taken place, threre is increasing evidence that career *gradations* based *on demonstrated practitioner competence* do have a positive effect on both practitioner and client satisfaction and organization quality. Nurses also find a positive inducement in recognition — and increased opportunity — for clinical practice.[5] Staff nurses in some settings are now working with master clinicians (nurses with graduate preparation) in direct care of patients and replacing the medicine nurse, head nurse, supervisors

hierarchy wherein the system, rather than patient care, is managed.

With a shift in the preparatory programs in nursing from hospital training schools to institutions of higher learning with a slow but significant start in clinical nursing research and with the increasing realization that nursing needs of people emanate from them — the patient and family — not from another profession's delegated activities and not from institutional or agency management, nurses stand ready to collaborate with medicine as knowledgable and skilled colleagues in planning the new day in health care delivery.

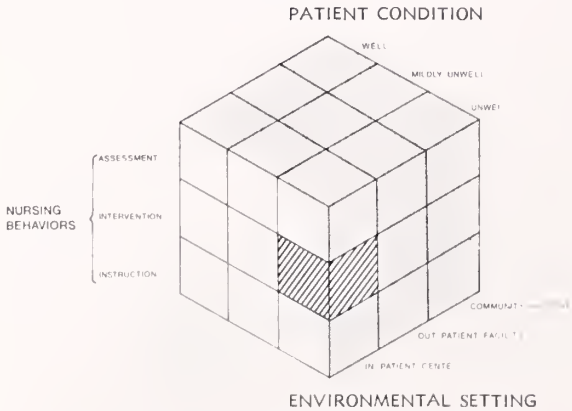
What is Nursing?

So often attempts to define nursing have been made by listing activities nurses can perform — these activities often are those the physician once did, but have subsequently been delegated to nursing. Activities can be delegated from one profession to another, functions cannot. While medically delegated activities are part of nursing, they are not the whole of it.

Nursing's *goal* is to maximize the potential of the individual in maintaining his own health at the optimum level. Nurses possess knowledge and skills needed for them to act, to preserve, and, promote normal (or as near normal as possible) functions of respiration, circulation, locomotion, digestion, elimination and socialization.

> "The condition which validates the existence of a requirement for *nursing* is the *absence of man's ability to maintain for himself* continuously that amount and quality of *self-care* which is *therapeutic in sustaining life and health, in recovery from disease or injury, or in coping with their effect.* — Therapeutic is used to mean supportive of life processes, remedial or curative as related to malfunction due to disease processes, as well as contributory to personal development and maturing."[5]

Figure 1



Interactive Model of Three Variables in Nursing Practice

In Figure 1, we note at least three dimensions on which nursing practice varies, and that the interactive product of these factors determines what is appropriate and necessary for nursing care at any given time.[6]

The three dimensions are the particular nursing behaviors, the patient condition and the environmental setting.

The prevailing image of the nurse, the noncreative provider of care to the unwell in in-patient centers, is illustrated in the one cube of Figure 1.

Optimal functioning in all cubes within this interactive model requires an autonomous role for nursing, traditionally fulfilled by nurse leaders but subsequently lost with the prolific demands made in nursing with increase in hospitalization and increasing sophistication of manifest illness care. It is not feasible for nursing, functioning within the broader framework of this model, to practice only within medical guidance/direction even were this acceptable to both medicine and nursing; which it is not. Rather, today's professional nurse must use the problem solving (scientific) method not at all unlike the process used by medicine in diagnosing and treating illness.

The Problem Solving Method is an essential process for the professional nurse. The art of nursing is embodied in a process which embraces a therapeutic use of self; a sustained respect for the dignity of the individual and his right to participate in decisions regarding his care; and a deliberate approach to identifying and meeting the individual's need for help.

The ability for critical thinking and to make decisions, either deliberately or with great speed, has ever been a part of the standard of conduct of the practitioner of professional nursing. This function shifts in complexity with scientific advancement in health care, for to do critical thinking and take appropriate action the nurse must be able to draw from the biological and physical sciences that are continually feeding new knowledge into the field of medical science and from the expanding knowledges in the social sciences and humanities. This function has long been recognized as an indisputable part of nursing practice but the selection of the proper word to describe the function (critical thinking and decision making) is a controversial issue for many see nursing as only a medically dependent occupation.

Since the time of Florence Nightingale, emphasis had been placed not only on the need to

observe but also how to observe. As a part of this process, early recognition was given to the complexity of data available to the nurse to use in making judgments about the state or condition of the patient. For years the observational task of the nurse consisted of three activities, namely — observing, recording and reporting. More recently, the observational functioning is now conceived to be a process that includes three specific operations: *observations* — recognition of signs and symptoms presented by the patient — *inference* — making the judgment about the state of patient and/or nursing needs of the patient and — *decision making* — determining the action to be taken that will be of greatest benefit to the patient. Assessing whether or not the selected intervention was truly of most benefit to the patient is the evaluative component of the nursing process.

Although all three operations — observation, inference, decision making, can best be described as cognitive functions, the second and third, inference and decision making, are clearly intellectual in character. These cannot be delegated. The nurse either has the ability to so function or she does not. If she does, she must be held accountable for her own acts. If she does not possess the knowledge necessary for the needed level of cognition, responsibility cannot be delegated to her without the delegation being negligent.

Naturally, every inference made by a nurse involves a risk of error, the nurse must be held responsible and accountable for her practice. She cannot be, nor does she desire to be, shielded from accountability by the fact that a physician did, or did not, give an order.

Nursing assistance is a continuous personalized service based on knowledges other than the physician's plan of medical care. The knowledge of the medical plan of care is essential, to be sure, (assuming the patient is under medical care) but other knowledges are equally significant to the nurse in formulating and carrying through her nursing plan.

1. Individual's perception of his health situation.
2. Individual's health status.
3. Individual's level of self help ability.
4. Individual's basic human needs and rights in health and sickness.
5. Health results or goal sought by and for the individual.
6. Availability of resources — family and community.

This is not to say the medical plan has ignored these factors. It may have taken into account one, or more, of them but they are the design of nursing. Personalized nursing services are based on these factors whether or not health clients are under the care of a physician.

The keynote of nursing is the determination of symptom and its alleviation, and the termination of a health state and how it is attained and maintained. The keynote of medicine is the diagnosis and therapy of manifest illness.

The well prepared nurse of today can be distinguished from her more physician dependent predecessor of 30 years ago and by an expanded knowledge base, keener powers of observation, ability to analyze physical, human and social phenomena, and ability to make correct inferences and initiate appropriate actions. She possesses knowledge, competence and good judgment. She is well prepared to know what she is doing and equally important, to know what she is not prepared to do.

The nurse, with her focus on the whole patient and his family rather than just the disease problem, has a broader concern than the physician and should be thought of as complementing what the physician does as well as what the patient and the community can do for themselves.

The nurse can reliably educate, assess, advocate, comfort, counsel, refer and give or arrange for necessary health services. She exercises surveillance over health and illness, and implements and manages care regimens prescribed by physicians.

The important thing is, whether a nurse is working alone in a physicianless community or in an organized health care program in association with physicians and others, she can function autonomously and responsibly in her own right as a licensed health care practitioner and is not necessarily limited to being just the doctor's helper and dependent on him for all she does. In spite of her education and her license, the nurse has functioned in a dependent manner too long.

How can we get on with building a personalized health system for all people?

Will Durant said: "The Health of a Nation is more important than the wealth of a nation."

I am not sure all in our affluent society are ready to accept that philosophy but I think all would agree the *health* of a nation can only advance the wealth of a nation; the morbidity — morality can only diminish a nation's potential.

The critical need for joint action demands that congruent roles be planned and articulated among the health professions.

The proliferation of groups without clarification and mutual respect for inter-dependent roles can only contribute to the untenable state of fragmented and excessive expensive care which leaves the patient, the public at large, physicians and nurses frustrated. Our roles, functions and professional relationships must be redefined and further developed through mutual trust and cooperative planning between the two professions most intimately involved: medicine and nursing.

A list of references may be obtained by writing The Journal.

Art and Science in Medicine

THE art of medicine may have been stressed unduly in the past and is still emphasized by many older physicians with a nostalgic yearning for its past contributions. "A science teaches to know, and an art to do." (Jevons)

There is obvious tense drama in the famous impressive painting by Sir Luke Fildes showing the physician sitting beside the sick child and observing its every breath most carefully and anxiously, as diphtheria takes its toll. Inherent too, however, is the deep frustration in just sitting there and being able to do so little; in that sense, it is a sad and maybe too dramatic depiction of the helplessness of the physician. The lesson is crystal clear, art itself is just not enough!

At the opposite pole is the totally objective approach—giving the calculated dose of antitoxin without any special tender loving concern for the sick child and anxious parents; but the child recovers. Does that mean that science is triumphant and the art of medicine is passe? Are the intangible emotional imponderables no longer important in medical care? Cannot the antitoxin be given with prayerful compassion too? The fact is that the art of medicine, although not so easily measurable and quantitative, statistical and "reportable," is still important and may be more so now than ever before. Man needs sympathetic understanding; the toll of lack of sympathy is great and can lead to callous, impersonal, and even harmful "care."

The difficulty arises out of the present tendency—a growing one—of contrasting art and science in medicine as if they were antagonistic. In truth, it should not be art versus science in medicine but rather art and science—in parallel, in symbiosis, both together affecting the cure of the body and the soul and achieving balanced health with permanent homeostasis and adjusted happiness.

Let us foster the art of medicine and promote its science too, together; there is a desirable proper balance between them for the best of medical care. One does not belittle the other, and there is no need to denigrate one for the sake of the other. Both can make an important contribution. Both are needed, much needed, to help troubled humanity in this troubled world.

With impersonal government and hospital controls of medical care ever increasing, it is only the physician who can properly balance the art and the science of medicine; he will be increasingly important in obtaining the best complete medical care for the patient. —*A.A.A., in New York State Journal of Medicine.*

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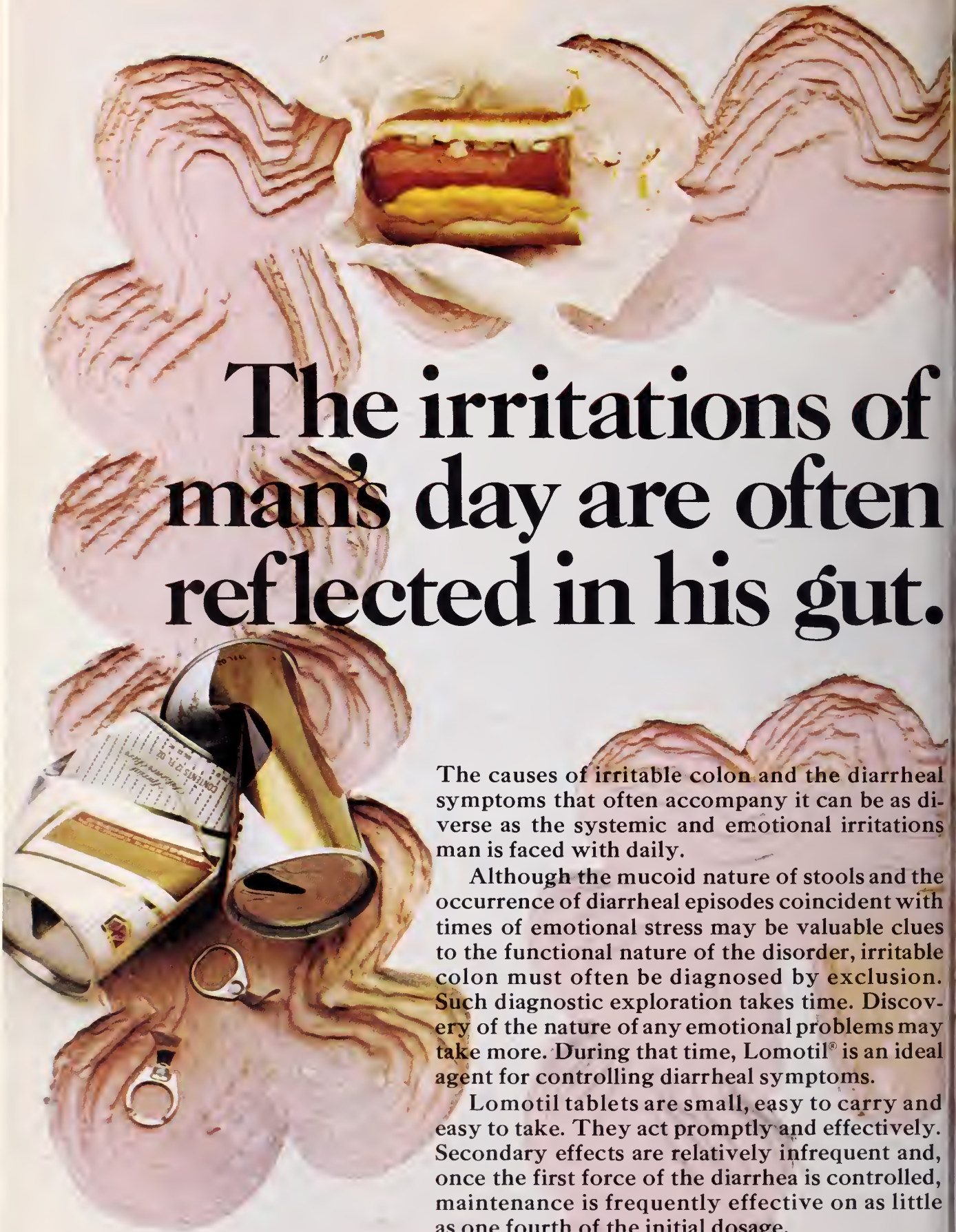

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Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

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Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents; and will include admission to a group buffet luncheon on Sunday, January 20. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

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The President

'ABCs' OF PATIENT'S RIGHTS

A "Patient's Bill of Rights" has recently been advocated by the American Hospital Association (AHA). On first blush it appears as a "motherhood" issue. Who could question it? However, on examination its major thrust is in doctor-patient relations. I question the propriety and wisdom not to mention the motive of this type sortie into sacred ground.

How refreshing it would have been for this group to have written rather the "ABCs" of patient's rights.

A. Administration. The patient has a right to an efficiently managed hospital administered with a careful balance maintained between cost control and quality of care—not to sacrifice one for the other.

B. Boards. The patient has a right to a board of trustees with a minimum of 25 per cent physician representation. The physician role should very properly be that of the patient's advocate.

C. Care. The patient has a right to expect courteous, compassionate and competent care from all hospital personnel from admission until final payment of his bill.

In summary, it would have been like a breath of fresh air for the AHA to have addressed itself to issues that it controls. To suggest to the public that the doctor-patient relationship is in any way controlled by the AHA is to further implicate the doctor in skyrocketing hospital costs—costs over which in most instances we have no control because of token representation upon the hospital governing boards.

A. Thomas McCoy, M. D., *President*

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EDITORIALS

MORE ON ABORTION: A CHILLING SUBJECT

After listening to a paper on "Abortifacients: Efficacy and Untoward Effects," presented at our annual meeting by Dr. Theodore M. King, Professor and Director of the OB-GYN Department at John Hopkins, this writer set down some of his thoughts as the basis for an editorial on the subject of abortions.

This topic has come under consideration in all states of the Union within the past two and one-half years as the result of a wide-ranging decision by the United States Supreme Court legalizing abortions upon demand on the basis of the inviolable individual rights of the woman involved.

The West Virginia law, unchanged since it was placed on the statute books in 1907, requires certification of medical conditions affecting the health of the mother to justify interruption of pregnancy, and provides certain safeguards in that more than one physician must approve an abortion procedure before it can be legally accomplished. Since the United States Supreme Court decision was handed down many state legislatures, notably New York and California, have liberalized their own state laws. In New York, according to Doctor King, between 1970 and 1972 over 300,000 abortions have been recorded. A somewhat smaller but still impressive number were done in California.

A bill was passed earlier this year by the West Virginia House of Delegates and State Senate altering West Virginia's abortion statutes but the joint conference committee failed to agree on a compromise bill, and so the matter died.

One of the chilling aspects of legalized abortion is a discussion such as the writer heard this morning. The speaker used the term "incredible" several times in his presentation. To this writer it is incredible that physicians can present in a very controlled and unemotional manner the statistics concerning abortion relating to the stage of pregnancy in which the abortions are performed—whether in the first trimester or the second trimester of pregnancy—the increase in morbidity and mortality occurring in the second trimester abortions, relative statistics of mortality as they apply to abortions performed in various countries such as Japan, Sweden, Czechoslovakia, England, etc.

Many physicians find it incredible that other physicians are able to base their professional decisions apparently primarily on the basis of the legality of the abortion procedure.. Many may find it incredible that the majority of serious complications of abortion occur in the teen-age patient and the majority of abortions are being done on women in their late teens. "The incredibly disorganized lives" of a large number of women in this age group lead to repeated preg-

nancy and abortion, according to the speaker, resulting in the necessity for placement of intrauterine devices in these post-abortion patients.

Possibly one of the most frightening aspects of this situation lies in the apparent willingness of the obstetrician-gynecologist—as well as the physician in other areas of medical practice—to view the subject of abortion and to accomplish the act itself with consideration limited to the physical and medically scientific aspects of the procedure. Great attention is directed toward methods, comparative morbidity of various methods, comparative mortality of various methods. There appears to be little in the medical literature pertaining to the responsibility of the physician toward his patient regarding social or moral implications of the procedure as they relate to her future, for example, or her future mental health.

Chilling was the revelation that certain attempts at abortion in the supposed second trimester of pregnancy had resulted in the birth and survival of premature infants. Especially so was the observation that a more rapid labor resulting from the introduction of the abortifacients in certain improved combinations had culminated in the birth of live fetuses, the point being that if there were a sufficient length of time lapsing between introduction of the prostaglandin and urea into the amniotic sac, the fetus would be killed before it could be delivered by induced labor. If certain combinations of drugs were used the labor was shortened so that the stay in the hospital could be limited to 24 hours or less, thereby reducing the cost of the procedure, but also resulting in an increased number of births of fetuses who were not killed prior to delivery.

Chilling was the revelation of possible and actual sequellae of abortions as they are developing among women who have subsequent pregnancies which they desire to bring to maturity. The incidence of prematurity, the necessity for Caesarian section because of lower uterine segment lacerations which occurred during the abortion procedure, the dangers attendant upon subsequent pregnancies, particularly when the patient is attended by a physician having no knowledge of previous complications, resulting from the abortion procedure—all were cited as post-abortion hazards. Usually not mentioned are crippling sequellae of venereal disease, the morbid and fatal complications attendant upon the widespread and uncontrolled use of contraceptive hormones and intrauterine devices.

The argument among philosophers and scientists, physicians and otherwise, goes on concerning the exact time at which life is imparted to an embryo. Many individuals, physicians and others, find this type of discussion depressing and repulsive.

Recently the nationally syndicated columnist, William F. Buckley, wrote a column on the abortion decision, mentioning the appeal by the State of Connecticut, in which the State of Connecticut reminds the Supreme Court that factual determination of the time at which life begins was ignored by the Supreme Court in its original decision; and that the issue of the constitutional right of a fetus is one that was not settled since the court stated that it "need not resolve the difficult question of when life begins."

Apparently at least 14 other states joined Connecticut as *amici curiae* in the case. Cited were instances in which Doctor Liley of the University of Auckland developed a technique of blood transfusions to *in utero* fetuses, having established definite diagnoses of RH diseases as early as the 14th week. He considered the infant to be a patient and thereby an individual with all the rights and privileges accruing to any patient. Mr. Buckley quoted the observation of Dr. Paul Rockwell, anesthesiologist at Leonard Hospital in Troy, New York, who observed about 1958 that while giving an anesthetic for a ruptured abdominal ectopic pregnancy at *eight weeks gestation* he observed a perfectly formed male embryo, one centimeter long, vigorously swimming in the amniotic fluid within the embryo sac.

As Mr. Buckley concluded, the Supreme Court might do well to recognize that there is a general soul-searching going on in America about the decision on abortion. So far, he points out, critics of the decision have mostly based their objections on the grounds that the Supreme Court decision was bad law and bad philosophy. The suit instituted by Connecticut and 14 other states is now saying, with rather irrefutable evidence, that in addition it was bad science, and that its factual basis was not only incomplete but incorrect.

WHAT DETERMINES THE LOCATION OF PHYSICIANS

An interesting and informative article appeared recently (August 8, 1973) in *Biomedical News* which concerns the relationship between physician density and per capita income of a state. The figures (obtained in 1970) show that physicians locate in states whose citizens have a high per capita income. Furthermore, the survey shows that the presence of a medical

school (or schools) in the state has no bearing on the density of physicians in the state.

A comprehensive chart accompanies the article which represents the relationship between the state's per capita income and the number of physicians per 100,000 residents. West Virginia is listed as having a per capita income of about $3,000 and 112 physicians per 100,000 people. There are 14 states which have as low or lower density of physicians as West Virginia. In the United States proper the two lowest are Mississippi with a per capita income of somewhat over $2,500 and South Dakota with a per capita income of about $3,150; the latter state has 88 physicians per 100,000 population and the former somewhat less than that. The state of New York has the highest per capita income and has by far the greatest density of physicians (about 240 per 100,000 people). There appear to be two exceptions, Alaska and Nevada; although these states have a relatively high per capita income they do not have a high physician density.

A number of examples are given which indicate clearly that the presence of a medical school (or schools) in a state has no effect on physician density. Apparently the presence of a medical school in a state is not generally considered an important factor by a physician seeking a place to locate. For example, New Jersey which for many years had no medical school, has a density of physicians greater than Illinois which has several medical schools, several of long standing. Pennsylvania and Rhode Island represent the United States average of physician density; the former state has a number of excellent medical schools, while the latter named state did not have a medical school for many years. Other examples could be given.

The survey emphasizes that the finding that many states with higher per capita income have more doctors per 100,000 people than states with more medical schools could ease agitation in some areas for the establishment of more schools to produce more physicians. This is an important consideration since presently more medical schools are either being planned or are in the course of development. It should be recognized by the citizens of a state that it is very expensive to maintain a medical school.

The fact that per capita income of a state is so important in determining the location of physicians is unwelcome news to citizens of West Virginia. It appears that until the per capita income of the state materially increases it will be difficult to solve the problem of physician shortage. Unfortunately, it takes a state a long time to raise significantly its per capita income. Other factors must be considered which would make it more inviting for physicians to locate in West Virginia. There are two important factors which may be quite helpful, namely the development of good roads and the establishment of good hospitals. Both of these factors can be accomplished. There is no magic way to solve the problem of shortage of physicians in West Virginia, but a sincere effort should be made by everyone in the State to help solve the problem; full cooperation of all its citizens is needed.

Memorial Tribute

MAYNARD P. PRIDE, M.D.

In announcing his election to the board of directors of the Federation of State Medical Boards, the *Bulletin* described Maynard Pride as a "man-hour philanthropist." Partially jocular, but mostly serious, the June 1972 issue recognized his willingness to assume increasing leadership responsibilities within the Federation, noting the enormous investment of time demanded of those with the enthusiasm and interest to accept the challenge. Extracted at the rate of an hour or two, or a few days at a time, with increasing frequency and predicted regularity, those elected to office in the Federation find their man-hour investment substantial—and *philanthropic*.

Maynard was elected to the board of directors of the Federation during the February 1972 annual business meeting.

He had been a member of the West Virginia Medical Licensing Board for many years and a member of the FLEX test committees (both clinical and basic sciences) from the time of the preparation of the first examination. A day or two before his death, Maynard had attended the mid-year FLEX committee meeting in Philadelphia during which the scores for the June 1973 examination were validated.

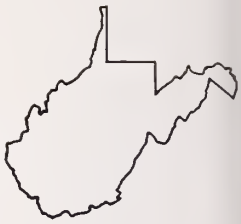
Relatively young by any standards (yet in his fifties at his death), nonetheless, Maynard had led and lived a full life—but likely one all too often emphasizing "service above self."

He will be sorely missed during coming meetings of the FLEX committee and at other Federation functions. And most certainly he will be missed by his students and house staff members as well as his professional colleagues at the West Virginia University School of Medicine and hospitals in Morgantown.

In concluding this brief tribute to one considered a good friend, the *Bulletin* echoes the appreciation of the Federation of State Medical Boards for the many years of such willing "man-hour philanthropy" so characteristic of Maynard P. Pride, M.D. There is little doubt that the success of FLEX came largely from the "man-hour investment" and enthusiastic support of Maynard and his kind.

Thus, this issue of the *Bulletin*—appropriately featuring FLEX in papers from the 1973 Examination Institute—is dedicated to his memory.—*Ray L. Casterline, M.D., Editor, Federation Bulletin.*

GENERAL NEWS



Report of Council Meeting At The Greenbrier

A meeting of the Council was held at The Greenbrier in White Sulphur Springs on Wednesday, August 22, with the Chairman, Dr. Harry S. Weeks, Jr., of Wheeling, presiding.

At the outset, those present stood for a moment of silent prayer in memory of the late Dr. Maynard P. Pride of Morgantown, who served as President of the West Virginia State Medical Association during 1969-70.

Doctor Weeks introduced the following two guests in attendance at the meeting: Dr. Russell B. Roth of Erie, Pennsylvania, President of the American Medical Association; and Dr. Carl E. Stark of Wytheville, Virginia, President of the Medical Society of Virginia.

Resolutions

It was reported that a larger number of resolutions than usual would be offered at the first session of the House of Delegates that afternoon. Doctor Weeks invited and urged all interested physicians to attend a meeting of the Resolutions Committee on Thursday afternoon.

(Subsequent action taken by the House of Delegates on the resolutions was reported in the October issue of *The Journal).*

New Family Practice Chairman

Dr. Charles E. Andrews, Provost for Health Sciences at the West Virginia University Medical Center, announced that Dr. John W. Traubert of Wellsburg had accepted appointment as Chairman of the Department of Family Practice at the WVU School of Medicine.

He said that Doctor Traubert would work on a part-time basis until April 1, 1974, at which time he would officially replace the acting chairman, Dr. Clark K. Sleeth.

Appointment of Ad Hoc Committees

Dr. N. H. Dyer, Director of the State Department of Health, requested that an ad hoc committee be named to assist the Medical Licensing Board in determining whether changes are needed to be made in the law governing licensure of physicians in the State. The Council requested Dr. A. Thomas McCoy, the incoming president, to appoint a committee in compliance with Doctor Dyer's request.

The Council also requested Doctor McCoy to appoint an ad hoc committee to investigate means of improving relationships between the practicing physicians and hospitals throughout the State.

1974 Meeting at The Greenbrier

It was reported that the management at The Greenbrier was holding the dates August 21-24, 1974, for the 107th Annual Meeting of the West Virginia State Medical Association.

The Council went on record unanimously as approving The Greenbrier as the place for the 1974 meeting during the above mentioned dates.

Report of Medical Economics Committee

Dr. W. Alva Deardorff, Chairman of the Medical Economics Committee, presented a report on activities of the Committee in recent months—especially discussions held with officials of the Workmen's Compensation Fund and the Division of Vocational Rehabilitation. He also announced that a meeting of the Medical Economics Committee would be held on Saturday morning, August 25.

Doctor Deardorff was congratulated for his efficient work as Chairman of the Committee during the past year.

Registration Fee for Non-Members And Out-of-State Physicians

The Council voted unanimously to charge a registration fee of $50 for non-member and out-of-state physicians attending the 1974 Annual Meeting at The Greenbrier. The registration fee will not apply to medical students, interns, residents and nurses.

Election of Honorary Members

Drs. E. V. Nutter of Gauley Bridge and P. D. Crynock of Morgantown were elected to honorary membership in the State Medical Association.

Report on PSRO Law

There was considerable discussion concerning latest developments in the implementation of the Professional Standards Review Organization (PSRO) legislation enacted by Congress in 1972. Also discussed was the development of a new non-profit, non-stock medical corporation to serve as a separate operating vehicle for scientific, educational and related activities.

(A complete summary of the action taken by the House of Delegates on this subject was published in the October issue of *The Journal.* Also, the most recent developments are reported in an article appearing elsewhere in this issue of *The Journal).*

Appearance of State Officials

Present at the meeting were the Hon. Samuel H. Weese, State Insurance Commissioner; Hon. Edwin F. Flowers, Commissioner of the Department of Welfare; and the Hon. William D. Mitchell, Acting Commissioner of the Workmen's Compensation Fund.

Also in attendance were Dr. J. L. Mangus, Medical Director of the Welfare Department; and Dr. Kenneth G. MacDonald, Part-Time Medical Consultant to the Workmen's Compensation Fund.

The three agency heads presented brief remarks and in turn answered questions from members of the Council. All were in agreement that relations between practicing physicians and the agencies had improved tremendously during the past few years.

Retiring Councilors

Doctor Weeks pointed out that the following four Councilors had completed two consecutive terms as members of the Council and therefore would not be eligible for reelection: Drs. Stephen D. Ward of Wheeling, Carl A. Liebig of Keyser, J. D. H. Wilson of Clarksburg and Joseph B. Reed of Buckhannon. He also announced that Dr. George V. Hamrick of Charleston was eligible for reelection but had decided not to seek another term.

The Council voted unanimously to express sincere appreciation and thanks to Doctor Weeks for his loyal and capable service as Chairman of the Council during the past year.

The meeting was attended by Dr. Harry S. Weeks, Jr., of Wheeling, Chairman; Dr. Worthy W. McKinney of Beckley, President; Dr. A. Thomas McCoy of Charleston, President Elect; Dr. William E. Gilmore of Parkersburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. George R. Callender, Jr., of Charleston, Councilor at Large; and Drs. Stephen D. Ward of Wheeling, Robert G. Janes of Fairmont, Charles E. Andrews of Morgantown, Thomas P. Long of Man, Robert R. Pittman of Martinsburg, J. D. H. Wilson of Clarksburg, Joseph B. Reed of Buckhannon, F. Lloyd Blair of Parkersburg, Jack Leckie of Huntington, W. Alva Deardorff of Charleston, Richard G. Starr of Beckley and John J. Mahood of Bluefield; and Mr. William H. Lively of Charleston, Executive Secretary, and Mr. Charles R. Lewis of Charleston, Special Projects Chairman.

The meeting also was attended by Dr. C. A. Hoffman of Huntington, Immediate Past President of the American Medical Association; Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Richard E. Flood of Weirton, AMA Delegate; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. Mildred Mitchell-Bateman of Charleston, Director of the State Mental Health Department; and Dr. L. J. Pace, a Past President of the State Medical Association.

Correction

An article entitled "Geographic Patterns of Infant Mortality in West Virginia" was published in the August 1973 issue of *The West Virginia Medical Journal.*

One of the authors has informed *The Journal* that the names of the co-authors in the by-line was listed incorrectly, through no fault of *The Journal.* We are advised it should have read "Mary Ellen Mazey, M.A., and Robert Davis, M.S."

The Section on Orthopedic Surgery held a meeting in conjunction with the Annual Meeting of the West Virginia State Medical Association at The Greenbrier in August. Dr. John B. Blakley of the Allegheny General Hospital in Pittsburgh (shown at the extreme left in the first row) was the guest speaker. During the business session of the Section meeting, the following new officers were elected for the coming year: Drs. Robert W. Lowe of Huntington, President; Robert L. Ghiz of Charleston, Vice President; and Arthur A. Abplanalp of Charleston, reelected Secretary-Treasurer. Dr. Robert R. Weiler of Wheeling is the Immediate Past President.

Program Participants Announced For Mid-Winter Conference

Eli H. Newberger, M.D., of Boston will be the first of 11 principal speakers appearing on the program of the Seventh Mid-Winter Clinical Conference in Charleston next January 18, 19 and 20 at the Heart-O-Town Motor Inn.

Ray W. Gifford, Jr., M. D.

Irving Kushner, M. D.

Doctor Newberger, who is Director of Family Development Studies at Children's Hospital Medical Center in Boston, will speak at a Friday evening session and again Saturday morning on "The Battered Child." The Friday evening session, which will be sponsored by the Woman's Auxiliary to the Kanawha Medical Society, will be open to the public.

Appearing with Doctor Newberger both Friday evening and Saturday morning will be a panel which will include Dr. John F. Kelley, child psychiatrist at the West Virginia University Medical Center; Dr. Carl J. Roncaglione, Charleston orthopedic surgeon; Patricia O'Reilly, Ph.D., psychologist with the Kanawha County Board of Education; Mr. Patrick B. O'Neal, Assistant Prosecuting Attorney assigned to the Juvenile Court of Kanawha County, and Mr. Julian Sulgit, Director of the Bureau of Child Protective Services, West Virginia Department of Welfare.

Dr. Herbert H. Pomerance, Charleston pediatrician, will be moderator at both sessions. Friday evening's public program is designed to state the problem of the battered child and what can be done about it. The Saturday morning session will be medically oriented.

Also scheduled Friday evening is a concurrent session consisting of an address and workshop on Professional Standards Review Organizations (PSRO's). Physicians will elect which Friday evening session they wish to attend.

Dr. Charles A. (Carl) Hoffman of Huntington will deliver opening remarks at the Saturday morning session.

Additional Speakers Announced

Other principal speakers not announced previously include Drs. John L. Guerrant, Professor of Medicine and Chairman of the Allergy and Pulmonary Disease Department at the University of Virginia School of Medicine, Charlottesville, whose subject will concern "Immunologic and Pharmacologic Basis for the Treatment of Asthma;" Charles B. Kahn, Joslin Clinic, Boston, "The Use of Oral Agents in the Treatment of Diabetes;"

Dr. Jack L. Le Frock, Assistant Professor of Medicine, Division of Infectious Diseases, WVU School of Medicine; Robert D. Patchell, Director of Obstetrics and Gynecology, Charleston Division, WVU Medical Center, who will discuss "Current Therapy of Non-Venereal Vaginitis;" and Michael F. Rein, Assistant Chief, Venereal Diseases Branch, Center for Disease Control, Atlanta, "Current Chemotherapy of the Venereal Diseases."

Drs. Guerrant and Kahn will speak at the Saturday afternoon session, January 19. As previously announced, Drs. Ray W. Gifford, Jr., Head of the Department of Hypertension and Nephrology, Cleveland Clinic; and E. Gordon Margolin, Director of Internal Medicine, Jewish Hospital, Cincinnati, also will speak at this session. Doctor Gifford's topic will be "Is It Worthwhile to Treat Hypertension?," while Doctor Margolin will discuss "Some Aspects of Diuretic Management."

Dr. Gifford Clinic Board Member

Doctor Gifford, who has been with the Cleveland Clinic Foundation since 1961, was named to the Board of Governors of the Foundation this year. A native of Westerville, Ohio, he received his bachelor of science degree from Otterbein College there, and his M.D. degree in 1947 from the College of Medicine at Ohio State University. He also holds a master of science degree in medicine from the Graduate School of the University of Minnesota.

Raymond B. Weiss, M. D.

Jack L. LeFrock, M. D.

Doctor Gifford interned at Colorado General Hospital in Denver, was a resident in internal medicine at University Hospital, Ohio State University, and held a Fellowship in Internal Medicine at the Mayo Foundation in Rochester, Minnesota. He is a Diplomate of the National Board of Medical Examiners and is certified by the American Board of Internal Medicine. His honors include the Alumni Achievement Award, Ohio State University College of Medicine, 1962; Distinguished Science Achievement Award, Otterbein College, 1970, and

the Meritorious Achievement Award of the New York Academy of General Practice, 1970.

Doctor Gifford is a Fellow of the American College of Cardiology and a former member of its Board of Trustees, a Fellow of the American College of Chest Physicians and Chairman of its Committee on Hypertension, 1970-72; a Fellow of the American College of Physicians, a member of the American Heart Association, and formerly a member of its Board of Directors (1969-72), and Chairman of its Stroke Council, 1970-72.

Dr. Mary Lou Lewis, Director of Medicine at Charleston Area Medical Center, will preside at the Saturday afternoon session.

Receives M.D. Degree In Holland

Doctor Le Frock will speak at the Sunday morning session, January 20. He was graduated from Lafayette College, received his master of science degree from Dalhousie University in Halifax, Nova Scotia, and his M.D. degree from the University of Amsterdam in Holland.

Also speaking Sunday morning, as previously announced, will be Drs. Raymond B. Weiss, Assistant Professor of Medicine, WVU Medical Center, on "Cancer Chemotherapy," and Irving Kushner, Professor of Medicine and Chairman of the newly-created Division of Rheumatology at WVU, "An Overview of Drug Therapy In Rheumatoid Arthritis."

Dr. Hartwell G. Thompson, Dean of the Charleston Division, WVU School of Medicine, will preside at the Sunday morning session.

A native of Washington, D.C., Doctor Weiss was graduated from the University of Minnesota and received his M.D. degree in 1965 from the same institution. He served a mixed medicine-surgery internship and two years of internal medicine residency at WVU.

Doctor Kushner, a native of New York, was graduated from Columbia College and received his M.D. degree from Washington University School of Medicine in St. Louis. He came to WVU from Case-Western Reserve University, where he had been a member of the medical faculty since 1958 and Director of the Arthritis Clinic of Cleveland Metropolitan General Hospital for the past 10 years.

Native of Canada

Drs. Patchell and Rein are scheduled for the Sunday afternoon program. Doctor Patchell is in charge of the academic program for medical students and house officers in the Charleston Division of the WVU School of Medicine. He received his premedical and medical education at the University of Toronto in his native Canada and also served his internship and residency in surgery in that country. Prior to his present appointment, Doctor Patchell had been on the staff of Harlem Hospital for eight years and held faculty appointments at Columbia University College of Physicians and Surgeons.

As previously announced, Dr. Clair E. Cox, II, Department of Urology, University of Tennessee College of Medicine, also will speak Sunday afternoon.

Doctor Cox received his M. D. degree in 1958 from the University of Michigan Medical School. He served a rotating internship and a residency in general surgery at the University of Colorado Medical Center in Denver, and a residency in urology at the University of California Medical Center in San Francisco. He is certified by the American Board of Urology and is a Fellow of the American College of Surgeons.

Presiding at the Sunday afternoon session will be Dr. John E. Jones, Acting Dean, WVU School of Medicine.

The annual Conference is sponsored by the West Virginia State Medical Association in conjunction with some of its component medical groups and volunteer health organizations. Drs. Ralph H. Nestmann and Joseph T. Skaggs of Charleston again are serving as Co-Chairmen.

A $15 registration fee for the Conference will cover the traditional Sunday noon buffet luncheon and some of the other expenses.

Kanawha Medical Society Offers Social Event

Physicians, wives and others attending the Mid-Winter Clinical Conference are invited to the annual dinner dance of the Kanawha Medical Society which will be held Saturday, January 19, in the Daniel Boone Hotel ballroom beginning at 7 P.M. The affair will include cocktails, dinner and dancing. Dress will be formal.

The cost will be $10 per person. Advance registration is requested. Registrations and advance payment, if desired, should be sent to the Kanawha Medical Society, 405 Atlas Building, Charleston 25301. Payment also may be made at the door. Checks should be made payable to the Kanawha Medical Society.

All registrations should be in by January 15.

Head And Neck Anatomy Course Set By MCV

A four-day course entitled "The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy" will be held at the Medical College of Virginia, Department of Anatomy, next January 21-24.

The primary teaching method of this course is the dissection of the head and neck. The tuition is $175; for students in residency programs, $90. The size of the class will be limited to 32. Further information may be obtained from Dr. Hugo R. Seibel, Department of Anatomy, Medical College of Virginia, Richmond, Virginia 23298.

Doctor Corbitt To Head Sports Conference At AMA Clinical

Dr. Richard W. Corbitt of Parkersburg will preside at the American Medical Association's 15th National Conference on Medical Aspects of Sports to be held during the AMA's annual Clinical Convention, December 1-5. Doctor Corbitt is Chairman of the AMA's Committee On Medical Aspects of Sports.

Richard W. Corbitt, M. D.

The Convention will be held in Anaheim, California.

The study of use of drugs by athletes in an effort to boost size and strength and enhance performance will be one of the areas concerning the health and safety of the American athlete to be studied at the Conference. Frank Gifford, American Broadcasting Corporation sports announcer, will be a luncheon speaker during the one-day program which will be held from 8 A.M. to 10 P.M. on Saturday, December 1, at the Royal Inn in Anaheim.

Other Convention activities will include the AMA Medical Services/Professional Standards Review Organization (PSRO) Conference on December 1, and the annual Aces and Deuces Luncheon on December 4.

The scientific program will be devoted to continuing medical education and will offer 30 postgraduate courses covering new treatments and techniques in most major specialties. There will be six scientific sessions, film symposia, scientific and industrial exhibits—all designed to help provide solutions to those every day health-care problems.

The AMA House of Delegates will hold its first session at 2 P.M. on December 2. West Virginia Delegates to the House are Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, with Drs. Harry S. Weeks, Jr., of Wheeling and George R. Callender, Jr., of Charleston, as Alternates.

In line with the usual schedule, Reference Committees of the AMA House will meet on Monday, December 3, to consider and hold hearings on the resolutions, reports and other items before them. The House will reconvene on Tuesday morning, December 4, for two additional days of sessions.

The complete program for the Convention was published in the October 15 issue of the *Journal of the American Medical Association.*

Dr. Spencer Named To Board

James T. Spencer, M.D., Charleston otolaryngologist, has been appointed by Governor Arch A. Moore, Jr. as the physician member of the West Virginia Board of Hearing Aid Dealers. Effective September 10, 1973, his term expires July 13, 1975.

State Doctors To Participate In SMA Convention

West Virginians will have prominent roles in scientific and business sessions of the Southern Medical Association's 67th Annual Scientific Meeting at the Convention Center in San Antonio, Texas. November 11-14.

Dr. Albert C. Esposito of Huntington, a Past President of the SMA, will continue as a member of the Board of Trustees until 1977.

Drs. Jack Leckie and William L. Neal of Huntington are Vice Chairman and Secretary, respectively, of the SMA's Section On Family Practice, which will meet on Monday, November 12. Doctor Leckie is Vice President of the State Medical Association.

Dr. D. Franklin Milam, Professor and Chairman of the Department of Urology at the West Virginia University School of Medicine, will present a scientific paper during a meeting of the Section on Urology on November 12. The title of his paper will be "Safety Problems Associated With Modern Electro-Surgery Units."

Dr. M. Bruce Martin of Huntington, a member of the SMA's Committee on Medical Students, will participate in an Orientation Session for Medical Student Representatives to be held Sunday afternoon, November 11. Doctor Martin and other committee members will present remarks to the students. Doctor Martin also is a member of the SMA's Council.

Bronco Junction Plans Series Of Counseling Sessions

The Allergy Rehabilitation Foundation of Charleston, sponsor of Camp Bronco Junction in Putnam County (a summer camp for asthmatic children) has planned a series of intensive follow-up family counseling sessions for weekend periods during the course of the current school year. The first session was held the weekend of October 12.

The purpose of the sessions are to evaluate the progress of the children who have attended the camp, reinforce the treatment plan of the child's physician, and provide parents with a better understanding of the family's role in the care of children with asthma.

Dr. Merle S. Scherr, Medical Director, announced that there would be individual consultations and group seminars conducted by specialists in allergy, psychiatry and psychology, as well as others experienced in the care of the asthmatic child.

The sessions will begin with a Friday night dinner and close following lunch on Sunday. The total cost for the followup program is $100 for two parents and one asthmatic child, plus $25 for each additional family member.

Futher information may be obtained by writing Dr. Merle S. Scherr, 805 Atlas Building, Charleston, West Virginia 25301.

Interesting Session Planned For 1974 Annual Meeting

A portion of the program during one of the general scientific sessions at the 1974 Annual Meeting at The Greenbrier will be devoted to a symposium on "What Are the Barriers to an Improved Medical Practice in the State of West Virginia?"

Dr. J. Hugh Wiley of Morgantown, Chairman of the 1974 Program Committee, announced that the open session would be held during the final portion of the scientific session on Saturday morning, August 24.

In order to develop the agenda for the symposium, Doctor Wiley has asked that an announcement be placed in *The Journal* to the effect that members of the Association are invited to send to him or to the office any complaints or suggestions as to how the practice of medicine can be improved in the State. He said this would enable his Committee to determine which complaints or suggestions were the most valid and should be placed on the agenda.

Doctor Wylie also stated that if a large number of complaints are voiced toward any particular state or governmental agency, an attempt will be made to have the heads of those agencies present to help provide answers to the questions.

Physicians wishing to send in suggestions for the agenda should direct same to either Dr. J. Hugh Wylie, 400 Drummond Street, Morgantown, W. Va. 26505; or to the West Virginia State Medical Association, P. O. Box 1031, Charleston, W. Va. 25324.

In addition to Doctor Wiley, other members of the 1974 Program Committee are Drs. John T. Chambers of Charleston, Philip M. Sprinkle of Morgantown, William E. Gilmore of Parkersburg, Ray M. Kessel of Logan, and Winfield C. John of Huntington.

Insurance Committee News

At the annual meeting in August, the Insurance Committee met with Home Office officials of the Ætna Casualty & Surety Company, Underwriters of our Professional Liability Program.

In addition to discussing actual claim experience, rating indications and such subjects as "Causes and Prevention of Malpractice Claims," it was also agreed the current common anniversary date of December 1 be changed to January 1 so as to coincide with a calendar year basis.

Ætna will extend your current policy's expiration date from December 1, 1973 to January 1, 1974. This will be done by endorsement and at pro rata premium charges.

These policies will then be renewed as a complete new liability package on an annual basis effective January 1, 1974.

Doctor Weeks First President Of New Medical Institute

Harry S. Weeks, Jr., M.D., of Wheeling is the first President of the new West Virginia Medical Institute, Inc., for a one-year term to end September 30, 1974.

Other officers chosen as the Institute's 15 charter members and Board of Trustees completed organizational procedures at September 30 meetings in Charleston are Oscar J. Bailes, D.O., Princeton, Vice President; Jimmie L. Mangus, M.D., Charleston, Secretary, and Robert R. Weiler, M.D., Wheeling, Treasurer.

The Institute's first Trustees include Doctors Weeks, Bailes and Mangus, and Philip M. Sprinkle, M.D., Morgantown, elected for three-year terms which began October 1; Doctor Weiler, along with Winfield C. John, M.D., Huntington; William E. Gilmore, M.D., Parkersburg, and George R. Callender., M.D., Charleston, for two-year terms; and A. Thomas McCoy, M.D., Charleston; Joseph B. Reed, M.D., Buckhannon, and Walter E. Klingensmith, M.D., and Worthy W. McKinney, M.D., both of Beckley, for one-year terms.

As this issue of *The Journal* went to press, all other licensed and practicing doctors of medicine and osteopathy in West Virginia were being invited to become members of the new non-profit, nonstock corporation on a voluntary affiliation basis. The Institute has no initial dues for three-year membership.

Primarily in line with planning extending over more than two years, the Institute has been established with a medical education base. It also is tailored as an organization of physicians qualified to apply to the U. S. Secretary of Health, Education and Welfare for a contract to establish and implement the Professional Standards Review Organization (PSRO) program in West Virginia, when and as such an application is proper.

Development of the Institute has had the endorsement and support of the West Virginia State Medical Association; its component societies, and the West Virginia Society of Osteopathic Medicine.

Envisioned as a "home" for expanded continuing medical education programs, the Institute also will provide a base for a unified approach by West Virginia's physicians to the challenges imposed by Congress' enactment of the PSRO legislation late in 1972.

The statute calls for establishment of a nationwide network of locally based review panels of physicians to insure that institutional care for Medicare, Medicaid and Maternal and Child Health programs falls within professionally set standards for quality, necessity and appropriateness of such care.

Dr. Scherr Speaks in New Jersey

Merle S. Scherr of Charleston was the guest speaker at the October 17 meeting of the New Jersey Allergy Society. His subject was "Rehabilitation of the Asthmatic Child."

Continuing Education Courses Reach Record Number

A total of 2,441 courses for continuing education for physicians will be offered by 697 institutions and organizations in the year which began September 1, the American Medical Association reported in a special supplement to the August 13 issue of its Journal.

This figure compares to 2,082 courses listed in the academic year ending August 31.

Institutions and organizations sponsoring courses to help physicians keep abreast of developments in medicine are located in 48 states and the District of Columbia.

Compiled by the staff of the AMA's Department of Continuing Medical Education, the supplement is the 19th annual listing of courses.

The list of courses is published as a service to all physicians who are interested in maintaining their competence and skill through the medium of formal courses and other organized activities in continuing medical education, says C. H. William Ruhe, M.D., the AMA's Director of Medical Education.

The number of physicians recognizing the value of regular, formal study has been increasing steadily and participation in the listed courses continues to grow, Doctor Ruhe points out.

A major factor in continuing medical education of physicians is the AMA's Physician's Recognition Award, presented to physicians who successfully complete specified study programs. Some 11,000 physicians qualified for the Award in 1972, bringing to more than 40,000 the total who have met the standards under this program.

Increased utilization of the AMA Award as a nationwide base for an acceptable level of continuing medical education has occurred, Doctor Ruhe says. The AMA now receives an increasing number of inquiries about the Award from physicians with medical staff responsibilities in hospitals. These inquiries ask the AMA to verify that a physician applying for hospital privileges has a currently valid Award, or how the Award can be used as a convenient way of validating participation by all medical staff members in a personal program of continuing education.

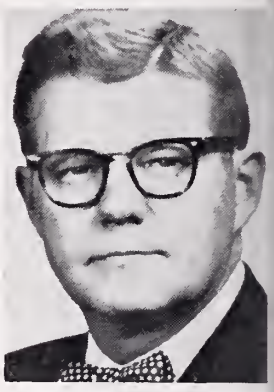
The Journal supplement lists courses that are sponsored by organizations accredited for continuing education by the AMA's Council on Medical Education. Every institution and organization known to offer such courses was contacted individually and offered the opportunity to list its courses. The list includes a high representation of almost every major course sponsor in the United States that is accredited for continuing medical education, Doctor Ruhe said.

Courses are listed under 44 different subject headings. Under each category the order of listing is alphabetical, first by states, then by cities within the states and finally by beginning dates of the courses.

Dr. Wilson Elected President Of Heart Association

Michael F. Wilson, M. D., Chairman of the Department of Physiology and Biophysics at the West Virginia University Medical Center, has been named President of the West Virginia Affiliate of the American Heart Association. He succeeds Dr. Harold Selinger of Charleston. Also elected at the recent Annual Meeting of the organization in Charleston were: Kenneth Weber, Ph.D., Morgantown, Chairman of the Board; Robert Harris, D.D.S., Ripley Vice Chairman; Leo H. T. Bernstein, M. D., Martinsburg, President-Elect; George Khoury, M. D., Morgantown, Vice President; John McComas, Huntington, Secretary; and Peter S. White, Charleston Treasurer.

Michael F. Wilson, M.D.



Herbert E. Warden, M.D.

A native of Morgantown, Doctor Wilson, the new President, graduated from West Virginia University and the University of Pennsylvania School of Medicine. He served his internship and residency at the Presbyterian Hospital of Philadelphia and was a Fellow in Cardiology at Temple University School of Medicine. He also was an Assistant Professor at the University of Kentucky College of Medicine before coming to West Virginia University in 1965. He has just completed a year's sabbatical as a Visiting Professor at the University of Nottingham Medical School, Nottingham, England.

In addition to his participation in the Heart Association, Doctor Wilson is a Fellow in the American College of Cardiolgy, and a member of the Aerospace Medical Association, American Physiology Society, Institute Electrical and Electronic Engineers, Pavlovian Society of North America, and the Association of Chairmen of Departments of Physiology. Doctor Wilson is listed in the American Men of Science, World Who's Who in Science, and Who's Who in the East. He has 66 publications to his credit.

Dr. Herbert E. Warden Honored

In recognition of his service to the American Heart Association and its West Virginia Affiliate, Dr. Herbert E. Warden, Professor of Surgery, West Virginia University School of Medicine, was given a special award at the Annual Meeting.

The award, a gold-inscribed wall plaque, is given only at those times when outstanding service to the Heart Association merits individual citation.

Doctor Warden, a thoracic and general surgeon, has been a member of the School of Medicine staff since 1960. He came to WVU from the University of Minnesota, where he was a member of the surgical team which won worldwide fame pioneering "open heart" surgical techniques.

In 1955, he and three other members of the team won the American Public Health Association's Albert Lasker Award for their studies in by-passing the circulation system of the patient, making open heart surgery possible.

Since joining the staff of the WVU Medical Center, Doctor Warden has done extensive research in the field of prosthetic (synthetic) heart valves and in methods of revascularizing heart muscles following coronary occlusion.

Morgantown's Doctor Curry Wins Golf Tournament

Dr. George A. Curry of Morgantown carded a 77 to finish one stroke ahead of Dr. Joseph T. Mallamo of Fairmont and win the Medical Golf Tournament held in conjunction with the West Virginia State Medical Association's 106th Annual Meeting at the Greenbrier in August.

Dr. James J. Morris, Jr., of Durham, North Carolina, with a 72, won low net honors, with Drs. J. Paul Aliff of Charleston, Philip M. Sprinkle of Morgantown and John J. Mahood of Bluefield each scoring a 73.

Dr. R. R. Summers of Charleston was the winner in low putts with 28, while Dr. Arthur A. Abplanalp of Charleston had two birdies to win that competition.

Georgetown Sponsors Cancer Symposium In January

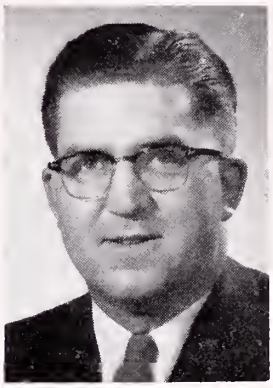
The Georgetown University School of Medicine will hold its first interdisciplinary symposium on cancer on January 18, 1974. The Vincent T. Lombardi Cancer Research Center at Georgetown will sponsor the one-day program, entitled "The Successfully Treated Cancer Patient—New Problems and Challenges."

Recent research has improved the treatment of cancer so that more patients are living either cured or with "arrested" disease. These patients present a new spectrum of problems—medical, psychological, social and economic. The symposium will focus on this new set of problems.

Pre-registration is required. For further information write: Lombardi Cancer Symposium, Room 1301, Georgetown University School of Medicine, 3800 Reservoir Road, N. W., Washington, D.C. 20007.

Dr. Carl B. Hall Elected Chairman of AAFP Board

Dr. Carl B. Hall of Charleston was elected Chairman of the Board of Directors of the American Academy of Family Physicians at the conclusion of that organization's annual meeting in Denver early in October.


Carl B. Hall, M. D.

Doctor Hall was elected to a three-year term as a member of the Board in 1971 during the annual meeting in Miami Beach that year. The AAFP is the national association of about 35,000 family physicians and more than 5,000 members were in attendance at the Denver meeting.

Dr. James G. Price of Brush, Colorado, was installed as the new President, succeeding Dr. James L. Grobe of Phoenix, Arizona. Dr. Herbert A. Holden of San Leandro, California, was named President Elect.

Doctor Hall, a native of Williamson, was graduated from West Virginia University and received his M. D. degree in 1940 from the Medical College of Virginia. He interned at Charity Hospital of Louisiana in New Orleans, 1940-41.

He served as a Major in the Medical Corps of the United States Army during World War II. He has been in the active practice of medicine in Charleston since 1946 and has participated in many activities of the Kanawha Medical Society and West Virginia State Medical Association programs. He served as President of the local society in 1959.

Doctor Hall served as Chairman of the Program Committee for the Annual Meeting of the West Virginia State Medical Association at The Greenbrier in 1971. In addition to membership on the AAFP Board of Directors since 1971 he also has served as Chairman of that organization's Insurance Committee.

New Fellows of ACS

Eight West Virginia physicians were inducted as Fellows of the American College of Surgeons in cap-and-gown ceremonies during the Annual Clinical Congress of the ACS in Chicago, October 15-19.

New members from West Virginia are as follows: Drs. Sungwhan Chang of Beckley, Romeo Y. Lim and William C. Morgan, Jr., of Charleston, Abdul Majid of Clarksburg, Robert W. Lowe and Tara C. Sharma of Huntington, Generoso D. Duremdes of Princeton, and Alfred D. Ghaphery of Wheeling.

Dr. E. Quentin Hull Assigned New Responsibilities by Carbide

Dr. E. Quentin Hull of South Charleston has been appointed Medical Director for Chemicals and Plastics of Union Carbide Corporation, the company announced in October. Doctor Hull had been serving as Medical Director of Carbide's South Charleston plant since 1960.

E. Quentin Hull, M. D.

"In his new position, at the South Charleston Technical Center, Doctor Hull will have administrative responsibility for the health programs of all our facilities in the United States and Puerto Rico," said T. W. Carmody, General Manager, Safety, Health, Environmental and Related Affairs for Chemicals and Plastics.

In addition, Doctor Hull will be involved in toxicology work done for Union Carbide at the Chemical Hygiene Center of Carnegie-Mellon University, and will assist Dr. C. U. Dernehl of the Corporate Medical Department.

"As a member of the department and its Environmental Affairs Management Team, Doctor Hull will play an important role in determining policy formulation, planning and in establishing priorities for my department's activities," Mr. Carmody said.

Doctor Hull, a native of Bartow, West Virginia, attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1948 from Northwestern University School of Medicine. He served as Secretary and President of Kanawha Medical Society and is a Fellow of both the American Academy of Occupational Medicine and the Industrial Medical Association.

Ten Additional Family Practice Residency Programs Approved

Family practice, a new medical specialty which came into being less than five years ago, is beginning to show tangible results in terms of producing more family doctors, according to a recent survey.

A total of 413 family physicians have graduated from approved family practice residency programs, the survey conducted by the Education Division of the American Academy of Family Physicians shows. Following behind are 1,771 family practice residents in training programs across the country, an increase of 756 over last year.

A recent meeting of the joint AMA-AAFP Residency Review Committee for Family Practice resulted in the approval of 10 programs, bringing the total number of approved residency programs to 173, an addition of 40 programs in the last year.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Nov. 4-8—Assn. Am. Med. Colleges, Wash.
Nov. 4-9—Am. Public Health Assn., San Francisco.
Nov. 7-9—Am. Cancer Society, New York.
Nov. 7-10—Am. Soc. of Cyt., Salt Lake City.
Nov. 8-12—Am. Assn. Cancer Educat., Honolulu.
Nov. 8-13—Am. Heart Assn., Atlantic City.
Nov. 12-15—Sou. Medical Assn., San Antonio.
Nov. 14-17—Am. Acad. of Neuro. Surgery, Pasadena.

Dec. 1-4—Am. Soc. Hematology, Chicago.
Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.
Dec. 3-5—So. Surg. Assn., Hot Springs, Va.

1974

Jan. 6-8—Soc. of Gyn. Oncol., Key Biscayne, Fla.
Jan. 18-20—Mid-Winter Clinical Conf., Charleston.
Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.
Jan. 19-24—Am. Acad. Ortho. Surgeons, Dallas.
Jan. 20-24—James C. Kimbrough Urol. Sem., Silver Spring, Md.
Jan. 21-23—Hemophilia (N. Y. Acad. of Sciences & Natl. Hemo. Found.) N. Y.
Jan. 25-27—So. Rad. Conf., Point Clear, Ala.
Jan. 25-27—AMA Natl. Leadership Conf., Chicago.
Jan. 28-30—Soc. of Thoracic Surgeons, L. A.
Feb. 1-3—AMA Council on Med. Educat. Congress, Chicago.
Feb. 10-16—Am. Soc. of Contemp. Ophthal., Miami Beach.
Feb. 10-16—Am. Soc. of Contemp. Med. & Surg., Miami Beach.
Feb. 11-14—Am. Coll. Card., N. Y.
Feb. 13-16—National Assn. Med. Examiners, Dallas.
Feb. 14-16—Soc. Univ. Surgeons, St. Louis.
Feb. 24-28—Med. Soc. State of N. Y., N. Y. City.
Mar. 1-3—Student Am. Med. Assn., Dallas.
Mar. 7-9—Central Surg. Assn., Cincy.
Mar. 15-17—AMA-AMPAC Pub. Affairs Workshop Washington, D. C.
Mar. 25-27—Am. Coll. Surgeons, Houston.
Mar. 28-29—Am. Bd. Med. Specialties, Chicago.
Mar. 29-April 3—Am. Soc. Abdom. Surgeons, Las Vegas.
Mar. 31—April 5—Am. Coll. Physicians, N. Y.
April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.
April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.
April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.
April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.
May 17-18—Am. Assn. Clin. Urologists, St. Louis.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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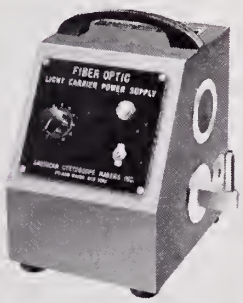

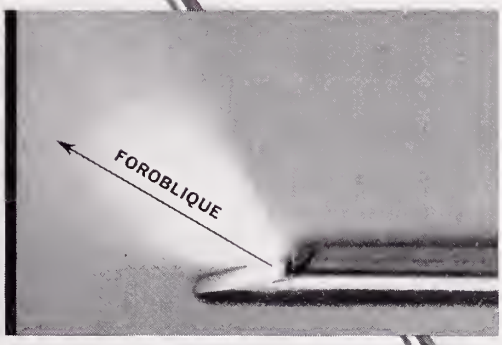

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WVU Medical Center
–News–

• **Compiled from materiol furnished by Mrs. Mory Ellin Wylie, Director, Medicol Center News ond Information Services, Morgontown, W. Vo.**

Two professors, one associate professor and three assistant professors have joined the faculty of the Department of Medicine, West Virginia University School of Medicine.

Dr. Irving Kushner, Professor of Medicine, also is Chairman of the newly-created Division of Rheumatology.

A native of New York, Doctor Kushner was graduated from Columbia College and received his M. D. degree from Washington University School of Medicine in St. Louis. He comes to WVU from Case-Western Reserve University, where he had been a member of the medical faculty since 1958 and director of the Arthritis Clinic of Cleveland Metropolitan General Hospital for the past 10 years.

Coming to WVU from California is Dr. Allen F. Bowyer, Professor of Medicine in the Division of Cardio-Pulmonary Diseases.

Doctor Bowyer, a native of Wisconsin, received his premedical training in physics and mathematics at Pacific Union College in Angwin, California, and his M. D. degree from Loma Linda University School of Medicine. Completing his internship at Hinsdale Sanitarium and Hospital in Illinois and a residency at St. Luke's Hospital in Chicago, he also was a postdoctoral research Fellow in cardiophysiology and an assistant in medicine at the University of Illinois.

Dr. Abnash C. Jain, Associate Professor, is a native of India and was educated at Panjab University and at the Royal College of Physicians in Edinburgh and London. He is a Fellow of the American College of Chest Physicians.

Cardiology is the sub-specialty of Dr. Barry Make, Assistant Professor of Medicine. A graduate of Jefferson Medical College, he completed his internship at Thomas Jefferson University Hospital in Philadelphia and his residency at the University of Michigan Hospital.

Dr. Jeffrey Shultz holds the appointment of Assistant Professor in both Medicine and Clinical Pathology. A graduate of Shepherd College, he received his M. D. degree from WVU and completed his internship and residency at University Hospital.

Dr. Jack L. LeFrock, Assistant Professor in the Division of Infectious Diseases, was graduated from Lafayette College, received his master of science degree from Dalhousie University in Halifax, Nova Scotia, and his M. D. degree from the University of Amsterdam in Holland. His internship was served at Brookdale Hospital in New York, where he also completed the first year of his residency. He continued his training in Cornell's Cooperating Hospital Program in New York and with a three-year infectious diseases fellowship at Tufts University School of Medicine in Massachusetts.

Basic Sciences Appointments

One associate professor and three assistant professors have joined the Basic Sciences faculty.

An Associate Professor of Anatomy, Duane Edwin Haines comes to WVU from the faculty of Virginia Commonwealth University. A graduate of Greenville College in Illinois, he received his master's and Ph. D. degrees in anatomy from Michigan State University.

Richard Gordon Frederickson, Assistant Professor of Anatomy, is a graduate of Pacific Lutheran University in his native state of Washington and received both M. S. and Ph. D. degrees from the University of North Dakota.

He comes to WVU from the University of Michigan, where he served as Instructor and Assistant Professor in Anatomy and as an Instructor in Light and Electron Microscopy.

Pedro Ramon Urquilla, Assistant Professor of Pharmacology, received his M. D. degree from the University of El Salvador in his native country and was a postdoctoral Fellow in biochemistry at Tulane University and in pharmacology at WVU.

His professional experience includes faculty positions at the University of El Salvador, where he was elected Dean of the School of Medicine in 1972, and one year as an Associate Professor of Pharmacology at the Universidad Autonoma of Madrid, Spain.

David Baetz Yelton, Assistant Professor of Microbiology, comes to WVU from the University of Maryland, where he was a postdoctoral Fellow in tumor virology and a lecturer in microbial genetics.

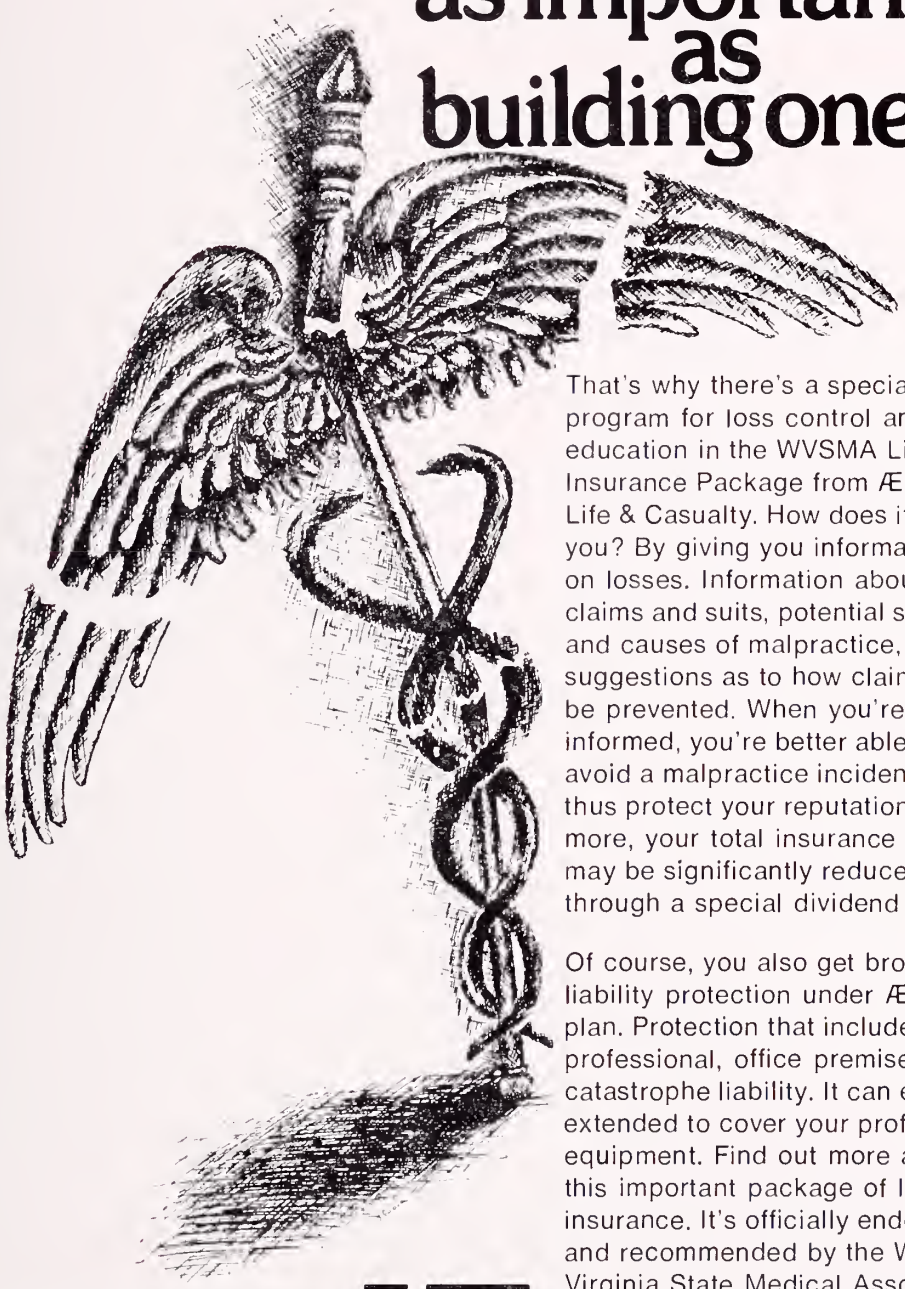
A graduate of Massachusetts Institute of Technology, he received his M. S. and Ph. D. degrees from the University of Massachusetts.

Microbiology Chairman Named

A former professor at the University of Iowa has been appointed Professor and Chairman in the Department of Microbiology.

Irvin S. Snyder, a native of Nanticoke, Pa., received his B. S. degree from Wilkes College and his M. S. and Ph.D. from the University of Kansas. His special areas of interest are pathogenic bacteriology, immunology and teaching methodology.

Protecting a reputation is as important as building one.



That's why there's a special program for loss control and education in the WVSMA Liability Insurance Package from Ætna Life & Casualty. How does it help you? By giving you information on losses. Information about actual claims and suits, potential sources and causes of malpractice, even suggestions as to how claims might be prevented. When you're better informed, you're better able to avoid a malpractice incident and thus protect your reputation. What's more, your total insurance costs may be significantly reduced through a special dividend feature.

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The Month in Washington

WILLIAM I. Bauer, M. D., has resigned as director of the controversy-ridden Professional Standards Review Organization (PSRO) program, expressing dissatisfaction with the PSRO organization setup.

The surprise step-down was a shock to the top officials at HEW who have been reeling from the loss of other high officials upset over the lengthy reorganization of the health activities at the HEW department.

Charles Edwards, M. D., Assistant HEW Secretary for Health, interrupted a planned business retreat to hurry back to Washington when the news of the resignation filtered out. He called a news conference but canceled it after the reporters had shown up. Doctor Edwards was in conference with HEW Under Secretary Frank Carlucci at that time.

The PSRO program is a particularly sensitive one to be subject to the inevitable repercussions and criticisms that follow a resignation. Members of the Senate Finance Committee have been taking a hard line on involvement of state medical societies in the PSRO review of institutional care under Medicare and Medicaid. Some physicians groups and state societies, and the PSRO advisory committee, have urged a broader authority for state societies. In general, HEW and Dr. Bauer had appeared to be attempting a middle course.

Futhermore, the gearing-up for the intricate and complicated program has been a mammoth task for Doctor Bauer.

The 48-year-old Doctor Bauer was named to the PSRO post last March after a career as a practicing internist in Greeley, Colorado. Other HEW officials who have resigned in the past several months are Gordon McLeod, M. D., Director of the Health Maintenance Organization (HMO) program, and Arthur Lesser, M. D., Head of Maternal and Child Health Services.

In a statement, Doctor Bauer said the administration has made a "significant commitment to PSRO but that commitment has not been translated into action. . . ."

"This extremely complex program with ramifications at all levels of medical care has been provided with limited resources and those resources that were made available could not be effectively administered and utilized because of the organizational structure," Doctor Bauer said.

- **From the Washington Office of the American Medical Association.**

According to an HEW spokesman, the resignation stemmed from a dispute between Drs. Bauer and Edwards over organizational control of the PSRO program. Doctor Bauer was said to believe that he could not exert meaningful authority under the present setup in which much of the field work for PSRO, involving hundreds of physicians, would not come under his line control but under the Bureau of Quality Assurance. Doctor Edwards, the spokesman said, contended that Doctor Bauer would still have the say-so, but Doctor Bauer obviously disagreed.

Underlying the dispute, apparently, has been the effort of Doctor Edwards to pry PSRO control away from Social Security and Social and Rehabilitation Services, present overseers of Medicare and Medicaid, and to give the Health Department clear jurisdiction in PSRO.

Under the reorganization, 50 physicians at Social Security and 150 in the Health Services Administration are assigned to PSRO but not directly under Doctor Bauer who had 36 staff positions.

There was no indication from Doctor Bauer of any philosophical differences with the administration over how PSRO would function at the local and state level.

HMO Legislation

The House has approved legislation that will provide federal funds to start a limited number of experimental Health Maintenance Organizations over a five-year period to the tune of $240 million. The Senate's version of HMO's, passed months ago, would provide $805 million over the same period. House and Senate conferees must now resolve the differences.

The compromise bill voted by the House calls for spending $60 million this fiscal year, the Administration figure. The bill meets many objections raised to the original measure by the Administration and the American Medical Association.

Though no specific number limitations was set in the House bill, the limit of authorizations to $240 million will provide an effective ceiling on the number of HMO's which could be established. The House Commerce Committee estimated the legislation would be used to bring to the operating stage approximately 100 new HMO's.

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Diplomate, American Board of Ophthalmology

Robert E. O'Connor, M.D.
Diplomate, American Board of Ophthalmology

Moseley H. Winkler, M.D.
Diplomate, American Board of Ophthalmology

Retinal Surgery
Fluorescein Angiography
Argon Laser Photocoagulation
Contact Lenses
Strontium 90 Beta Irradiation

OTOLOGY

William C Morgan, Jr., M.D.
Diplomate, American Board of Otolaryngology

OTOLARYNGOLOGY

Romeo Y. Lim, M.D.
Diplomate, American Board of Otolaryngology
Micro-surgery
Maxillo-facial Surgery
Reconstructive Surgery
Head & Neck Surgery
Cryosurgery
Endoscopy
Oncology

OPHTHALMOLOGY and OTOLARYNGOLOGY

John B. Haley, M.D.
John A. B. Holt, M.D.
Diplomate, American Board of Ophthalmology

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Orthoptics
Visual Fields—Flow Studies
Laboratory
X-ray
Audiometry

Audiology

Nancy McClung, M.S.

Anesthesia

Catherine Kenney, CRNA
Inez Maggio, CRNA
Muriel Dodds, CRNA

Obituaries

JOSEPH W. CARNEY, M.D.

Dr. Joseph W. Carney of Newport News, Virginia, formerly of Logan, died on August 19 in Newport News. He was 64.

A native of Portsmouth, Virginia, Doctor Carney was graduated from the College of William and Mary and received his M.D. degree in 1933 from the Medical College of Virginia in Richmond.

He practiced in Logan from 1935 until 1946 when he moved to Newport News. He served as Secretary and President of the Logan County Medical Society and also was a member of the West Virginia State Medical Association and American Medical Association.

* * * *

ROBERT D. HARMAN

Dr. Robert D. Harman of Howey-in-the-Hills, Florida, formerly of Kingwood, died on September 16 in the Naval Hospital at Quantico, Virginia. He was 76.

A native of Riverton, West Virginia, Doctor Harman was graduated from West Virginia University in 1920 and received his M. D. degree in 1922 from the University of Maryland School of Medicine. He had practiced medicine in Kingwood for a number of years before retiring and moving to Florida in 1959.

Doctor Harman was a veteran of both World Wars I and II. He served with the Medical Corps of the United States Army during World War II and was discharged with the rank of Lt. Colonel. He was an honorary member of the Preston County Medical Society, West Virginia State Medical Association and American Medical Association.

He is survived by his widow, Virginia Harman of Howey-in-the-Hills, Florida; a daughter, Mrs. Ann Dodrill of Orlando, Florida; and two grandchildren.

* * * *

FRANK M. MULDOON, M.D.

Dr. Frank M. Muldoon, family physician who had practiced in the Salem (Harrison County) area for 20 years, died on September 20. He was 51.

A native of Shepherdstown, Doctor Muldoon received his undergraduate degree, a bachelor of science in education, in 1943 from Ohio University. He earned his M. D. degree in 1949 from the University of Rochester (N. Y.) School of Medicine and interned at the University of Pittsburgh Medical Center.

His father, the late John D. Muldoon, was a professor at Salem College. Doctor Muldoon was a member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are the widow; two sons, John D. and William Muldoon; one daughter, Roberta Muldoon, all at home; and one sister, Mrs. Bernard Sullivan of Milton.

STATEMENT REQUIRED BY THE ACT OF OCTOBER 23, 1962; SECTION 4369, TITLE 39, UNITED STATES CODE SHOWING THE OWNERSHIP, MANAGEMENT AND CIRCULATION OF THE WEST VIRGINIA MEDICAL JOURNAL.

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I certify that the statements made by me above are correct and complete.

(Signed) William H. Lively,
Managing Editor

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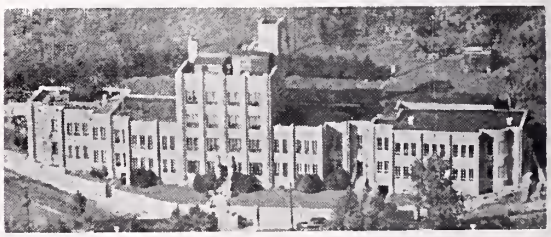

Radiology:
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Pathology:
Fulvio Franyutti, M. D.

Surgery:
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
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J. W. Woodford, M. D.

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Internal Medicine:
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County Societies

MERCER

Mr. Charles R. Lewis, Special Projects Director for the West Virginia State Medical Association, was speaker for the meeting of the Mercer County Medical Society on September 17 in Bluefield at the University Club. Mr. Lewis discussed Professional Standards Review Organizations (PSRO's) and the West Virginia Medical Institute, Inc., which is being organized as a structure which will be eligible to enter into possible contracts with proper Federal officials in implementation of the PSRO law.

Mr. Lewis answered many questions following his presentation.

Mr. Alan Goodykoontz talked about Schedule II drugs and stated that nine barbituates would soon be placed on Schedule II. This means that a written prescription will be necessary and that these drugs cannot be re-filled.

Dr. John J. Mahood reported on the Annual Meeting of the State Medical Association and its Council held in August at The Greenbrier.

A donation of $30 was approved for *Pylon*, the West Virginia University School of Medicine's Annual.—John J. Mahood, M. D., Secretary.

McDOWELL

The McDowell County Medical Society met on September 12 in Welch at Stevens Clinic. The Society voted to sponsor a Diabetes Detection Drive to be conducted in the county November 11-17. With blood sugar to be the official test, the Society will seek the help of county service organizations in promoting and coordinating the effort to get county citizens to take the test.

Dr. Arthur A. Carr of Welch was elected to serve as Secretary for the remainder of 1973. He replaces Dr. Emilio Delgado, who has left the county.—A. A. Carr, M. D., Secretary.

* * * *

HARRISON

The Harrison County Medical Society met on Thursday, October 4, at the Stonewall Jackson Hotel in Clarksburg.

The guest speaker for the evening was Mr. Eric Springer, a Pittsburgh attorney and a member of the Hospital Attorneys of America, who spoke on Professional Standards Review Organization (PSRO).

Drs. Aristotle Rabanal, Creel S. Cornwell, Jr., Robert O. Pletcher and C. S. Krishna Murthy were unanimously elected to membership.

A memorial was read for Dr. Frank M. Muldoon of Salem who died on September 20.—Ray A. Harron, M. D., Secretary.

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MONONGALIA

Dr. Albert S. Klainer was the principal speaker at the meeting of the Monongalia County Medical Society on September 4 at the Old Mill Club in Morgantown.

Doctor Klainer, Chairman of the Division of Infectious Diseases at the West Virginia University School of Medicine, spoke on "A Rational Approach to Infectious Diseases."

Dr. Clark K. Sleeth introduced Dr. John W. Traubert, the new Chairman of the Department of Family Practice at WVU, and gave a historical background of the development of the Department of Family Practice and the policies of the new program.

Dr. Margaret I. Stemple, President of the Society, gave a report on the recent Professional Standards Review Organization (PSRO) meeting in Charleston which she attended with three other representives from Monongalia County. She stated it was the opinion of this group that there should be one PSRO for the state which should be under the guidance of the West Virginia Medical Institute, Inc. with local involvement of physicians on a rotating basis.

Dr. Isaiah A. Wiles commended Dr. Eldon B. Tucker of Morgantown, Chairman of the State Medical Association's Committee on Aging, for his enthusiastic work with that committee, pointing out that Doctor Tucker was the author of the Transportation Stamp Program for the Aged.

At the request of the President, the Society stood for a moment of silent prayer in memory of Dr. Maynard P. Pride.

There were approximately 50 members and four guests present. The guests included Drs. John E. Jones, Acting Dean of the WVU School of Medicine; John W. Traubert, Roland J. Weisser, WVU Department of Family Practice; Jack L. LeFrock, Division of Infectious Diseases; and Leonard L. Peters, Chief Resident in the Department of Surgery.—H. Summers Harrison, M. D., Secretary.

Student Grants Increased By PMA Foundation

The Pharmaceutical Manufacturers Association Foundation recently announced an intensification of its Medical Student Research Fellowship program to increase grants to individual students from $1,000 to $5,000 a year.

The $5,000 stipends will be awarded each year to four highly motivated candidates who are interested in research and teaching careers in pharmacology-clinical pharmacology, and who will devote one year full-time to a specific research effort in these fields, said Thomas E. Hanrahan, Executive Director of the PMA Foundation.

A candidate for the fellowship must be currently enrolled in a medical school and have completed at least one year of the school curriculum. The deadline for applications is January 15, 1974. Awards are to be made for the year beginning July 1, 1974, and will be announced on or before March 15, 1974.

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Northern Regional Director: Mrs. John D. H. Wilson, Clarksburg
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Corresponding Secretary: Mrs. W. Paul Elkin, Charleston
Parliamentarian: Mrs. Robert G. Janes, Fairmont

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society met at the home of Dr. and Mrs. James A. Thompson on September 20.

Mrs. J. Dennis Kugel, President of the State Medical Auxiliary, was introduced and spoke briefly. Also, prospective members and guests were introduced.

The Auxiliary also held a dinner meeting on October 4 at the Stonewall Jackson Hotel in Clarksburg. The Rev. Reva Thurmond, on-campus minister of the United Methodist Church, West Virginia University, was the guest speaker. Her topic was "The Emerging Woman."

Mrs. William N. Walker, Jr., President of the Auxiliary, presided at a brief business meeting—Mrs. Richard F. Fiester, Publicity Chairman.

* * * *

KANAWHA

Dr. Mildred Bateman, Director of the West Virginia Department of Mental Health, was guest speaker at the meeting of the Woman's Auxiliary to the Kanawha Medical Society held on September 11 at the home of Dr. and Mrs. Jack Puskin in Charleston.

Doctor Bateman's topic was "What's New in Mental Health." Manpower and money crunches may make the last part of setting up community mental health centers more difficult than the first part, Doctor Bateman told the Auxiliary members. She said sites have been purchased, ground is being broken, or bricks and mortar are actually flowing into place for most of the 14 mental health service areas in the state.

Doctor Bateman said Kanawha County's mental health complex, which is to be developed in conjunction with a community health facility to serve four counties, has hit a money snag, making necessary a request for additional funds from the Legislature. She praised physicians for "seeing to it that Kanawha County was chosen as a place for the complex so we can tie in with other progressive programs being developed and going on at Charleston Area Medical Center."

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James A. Gordner, M. D.

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Cliffard A. Stevensan, M. D.
S. A. Zahir, M. D.
Mario C. Ramas, M. D.

Obstetrics-Gynecology
Charles W. Merritt, M. D.
Warren D. Elliott, M. D.
Owen C. Meadows, M. D.
Robert P. Pulliam, M. D.
T. J. Ma-Luf, M. D.

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Edward T. Liu, M. D.

Urology
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Jase L. Oyco, M. D.
Eugene Warvariv, M. D.
R. James Yates, M. D.

Pediatrics
P. B. Gogo, M. D.
R. G. D. Cancepcian, M. D.

Ear, Nose & Throat
P. C. Carro, M. D.

Radiology
Thomas L. Martin, M. D.

Clinic Manager
James P. Bland

Other subjects discussed by Doctor Bateman included: current attempts to provide housing and financial support for community living for the aged and adult mentally retarded who do not belong in mental hospitals, community facilities for the mentally ill child, plans to use three residences at Guthrie Center (Kanawha County) for graduate students in child development and social work to work with children identified by the county school system as having learning problems and problems of social adjustment, and the day-to-day problem of getting adequate staffing and keeping existing services going.

Speakers for the October meeting were Don Arnwine, President of the Charleston Area Medical Center, and Hartwell G. Thompson, M. D., Dean of the Charleston Division of the West Virginia University School of Medicine. With the decreasing number of new physicians coming into the Charleston area and the average age of physicians being 54 years, the speakers said, hospital merger and affiliation with a medical school is a possible solution to the problem of physician shortage. They were discussing the creation of the CAMC and its affiliation with WVU.—Mrs. Spencer L. Bivens, Jr., Press and Publicity.

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Robert T. Brandfoss, M. D.
A. Athari, M. D.
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D. C. Trapp, M. D.
Dermatology:
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Stephen D. Ward, M. D.
Michael McNeer, M. D.
David Hill, M. D.
David H. Smith, M. D.
Robert L. Mendelsan, Ed D.
Roentgenology:
A. K. Butler, M. D.
J. N. Aceto, M. D.
Speech Pathologist and Audiologist:
James P. Frum, M. S.
Clinical Laboratories:
Donna Burlenski
Donna Bryan
Technologists:
Electrocardiography:
Betty Maguire, R. N.
Brenda Muklewicz, R. N.
Electroencephalagrophy:
Joann Green, R. N.
Juanita Stone, R. N.
Raentgenalagy:
Evelyn Forester, R. T.
Administration:
Lester L. Cline, Manager
Henry L. Castilow, Asst. Mgr.

Book Reviews

DR. THOMPSON'S NEW WAY FOR YOU TO CURE YOUR ACHING BACK—By Jess Stearn. Doubleday & Company, Inc., 277 Park Avenue, New York, N. Y. 10017. 1973. Pp. 203, with numerous illustrations. Price $7.95.

The book, "Doctor Thompson's New Way for You to Cure Your Aching Back," is based upon the chiropractic assumption that multiplicity of diseases are due to subluxation of the sacral iliac joint—the correction of which by simple manipulation can cure not only backaches but a multiplicity of physical illnesses as well as mental problems.

Listed through the book are various statements which are well-known medical facts and are unrelated to the manipulations which are recommended in the treatment of backaches. The diligent following of the manipulations and exercise program in the book may be of some benefit but cannot be considered to improve pathological back problems. Such exercise programs and manipulations may lead to more serious complications.—George R. Callender, Jr., M.D.

Count that day won when, turning on its axis, this earth imposes no additional taxes.—E. P. Adams.

'Heart Saving' Programs Emphasized In Association's Report

With an emphasis on programs and community service to citizens of the State, the West Virginia Affiliate of the American Heart Association is "moving forward to serve," according to the 1972-73 Annual Report of the organization.

Among the programs financed by the Heart Fund dollar are continuing efforts in rheumatic fever prevention, cardiopulmonary resuscitation (CPR) training, heart sound screening, hypertension screening, public and professional education and heart research.

Approximately 800 West Virginians are now receiving penicillin at a reduced rate through a rheumatic fever prevention program of the Heart Association and the cooperation of 700 physicians and 150 pharmacists. CPR training sessions are being conducted throughout the state to teach the life-saving method to instructors who will qualify to train others. Heart sound screening is being carried out in schools in some areas of the state where heart sounds can be monitored accurately.

Heart research is still a high priority of the Heart Fund dollar, with an allocation of 26 percent. Twelve investigators in West Virginia have been conducting research in an effort to find new discoveries about heart disease.

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EMERGENCY ROOM PHYSICIAN — Accredited 280-bed progressive general hospital in beautiful Huntington, West Virginia; excellent income and working conditions; send resume to Assistant Administrator, Cabell Huntington Hospital, 1340 Sixteenth Street, Huntington, West Virginia 25701.

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NOTICE—Grafton City Hospital is pleased to announce its affiliation with Alderson-Broaddus College as a primary institution for the training of physicians assistants and nurses. Needed to augment the medical staff are a general practitioner, internist and an obstetrician-gynecologist. New hospital will be completed within three months and the training program will start in September 1973. Salary and subsidies can be arranged. Contact Wallace B. Murphy, M.D., Chief of Staff, Grafton City Hospital, Grafton, West Virginia 26354.

FAMILY PHYSICIANS—To practice at Jackson General Hospital and in the Ripley-Ravenswood area of West Virginia. Excellent opportunities in a prosperous area with tremendous growth potential. Salary guarantee for first year. Contact Administrator, Jackson General Hospital, Ripley, West Virginia 25271. Telephone: (304) 372-2731.

WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mrs. J. Carl Rinehart, Pennsboro, W. Va.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

WANTED—General practitioner, internist, pediatrician and emergency room physician to associate with other specialties in small town in Southern West Virginia. Accredited 82-bed hospital and new clinic building. Excellent working conditions. Short-term appointments available. Contact Jorge J. San Pedro, M.D., Man, W. Va. (304) 583-6541.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

WANTED IMMEDIATELY—General practitioner for a modern 40-bed well-equipped hospital. Income limited only by desire and ability. Write or call Administrator, Hampshire Memorial Hospital, Romney, W. Va. 26757. Phone (304) 822-3514.

WANTED—Two general practitioners in Marlinton, Pocahontas County. A 42-bed general hospital is available. Successful practice practically assured and assistance will be offered in locating office space. Call Mr. S. E. Drumm, Administrator, Pocahontas Memorial Hospital in Marlinton, collect, for particulars (304) 799-4193.

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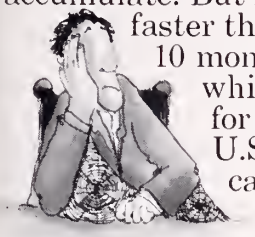

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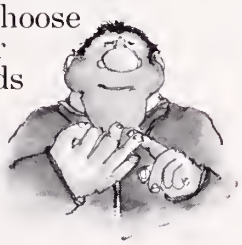

If you need a shove to get you saving, we can do that too.
All you have to do is sign up for the Payroll Savings Plan at work. Then an amount you specify is set aside from your paycheck each month and used to buy Bonds. While you use your take-home pay for immediate needs, you're also building a nice nest egg. Automatically.

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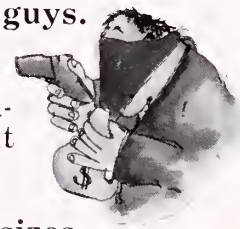

They come in all sizes, but they fit everyone.
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U.S. Savings Bonds. What it comes down to is taking stock in yourself.

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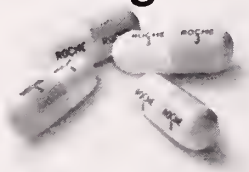

For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.

basic support in severe anxiety

Librium® 25 mg (chlordiazepoxide HCl) 1 capsule t.i.d./q.i.d.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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. 69 No. 12

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to the profession on request.

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DECEMBER 1973

Everybody experiences psychic tension.

Most people can handle this tension.

Some people develop excessive psychic tension and need your counselin

and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium
ızepam) part of your treatment
n, check on whether or not the
ient is presently taking drugs
l, if so, what his response has
n. Along with the medical and
ial history, this information can
p you determine initial dosage,
possibility of side effects and
ultimate prospects of success
ailure.

While Valium can be a most
pful adjunct to your counseling,
hould be prescribed only as long
xcessive psychic tension per-
s and should be discontinued
en you decide it has accom-
shed its therapeutic task. In
ıeral, when dosage guidelines
followed, Valium is well
rated (see Dosage). For con-
ience it is available in 2-mg, 5-mg
l 10-mg tablets.

Drowsiness, fatigue and ataxia
e been the most commonly re-
ted side effects.

Until response is determined,
ients receiving Valium should
cautioned against engaging in
ardous occupations requiring
nplete mental alertness, such
driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N J. 07110

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(diazepam)

To help you manage excessive psychic tension

DECEMBER
1973

Vol. 69 No. 12

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

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acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

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Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations

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The Board of Directors of the American Academy of Family Physicians

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The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associat

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is o affirm the support of the participat- ng organizations for the laws, regula- ions and professional traditions which rohibit the unauthorized substitution f drug products.

Traditionally, physicians, den- ists and pharmacists have worked cooperatively to serve the best inter- ests of patients. Productive coopera- ion has been achieved through mutual respect as well as a common concern for the ideals of public ervice. This mutual respect has been eflected, in part, by joint support ver the years for the adoption and nforcement of laws and regulations pecifically prohibiting unauthorized ubstitution and encouraging joint iscussion and selection of the ource of supply of drug products. The basic principles of medical, den- al and pharmacy practice are thus tilized and preserved in the interest f patient welfare.

The antisubstitution laws have ot obstructed enhancement of the rofessional status of pharmacy any more than they have in and of them- elves guaranteed absolute protec- ion from unsafe drugs, or freed hysicians, dentists and pharmacists rom their responsibilities to patients. As a practical matter, however, such aws and regulations encourage inter- rofessional communications regard- ng drug product selection and assure ach profession the opportunity to xercise fully its expertise in drug sage, to the advantage of patients.

Physicians and dentists should e urged to increase the frequency nd regularity of their contacts with harmacists in selection of quality rug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

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Wherever it hurts, Empirin Compound with Codeine usually provides the relief needed.

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#3, codeine phosphate* (32.4 mg.) gr. ½
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We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

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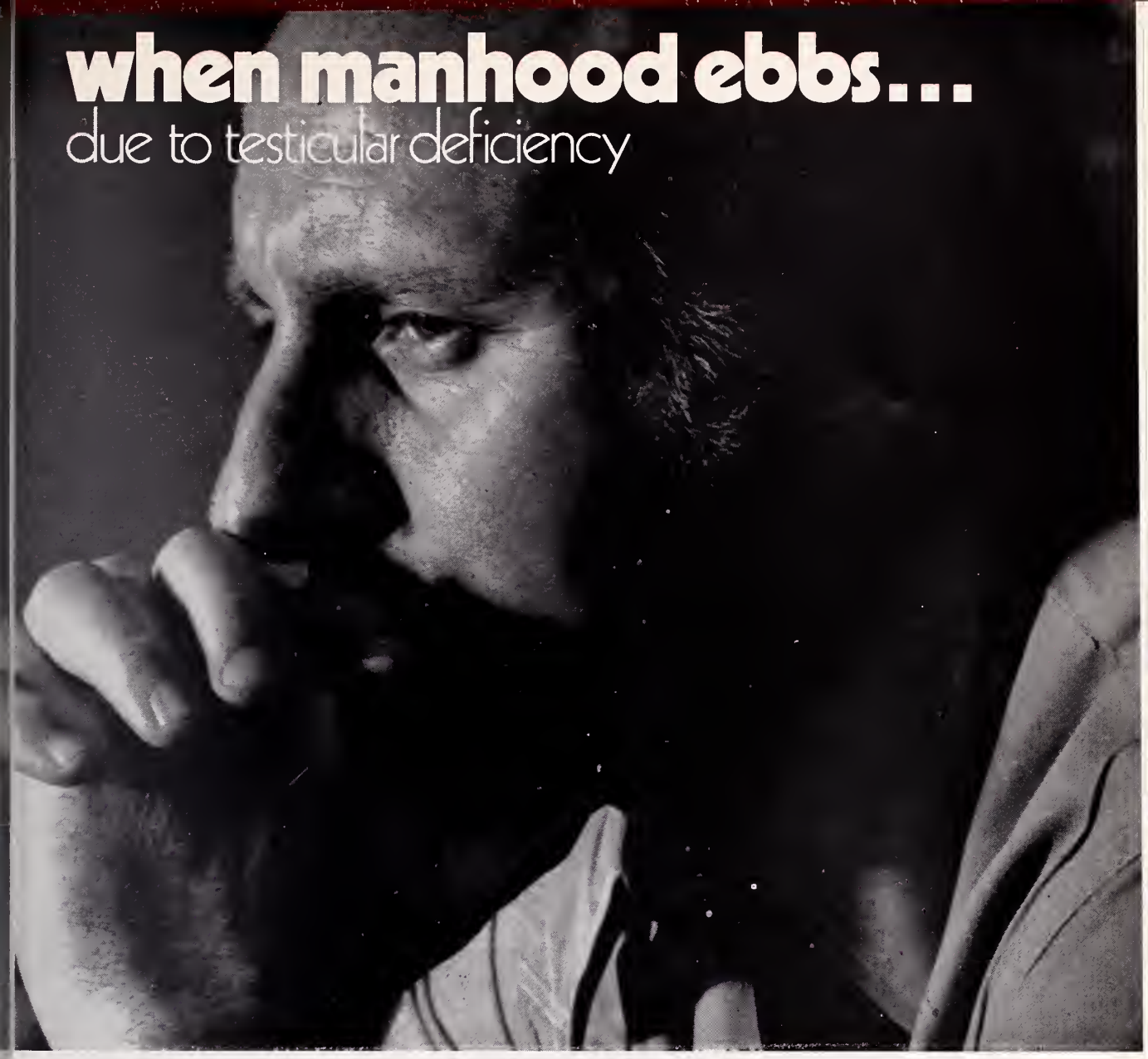

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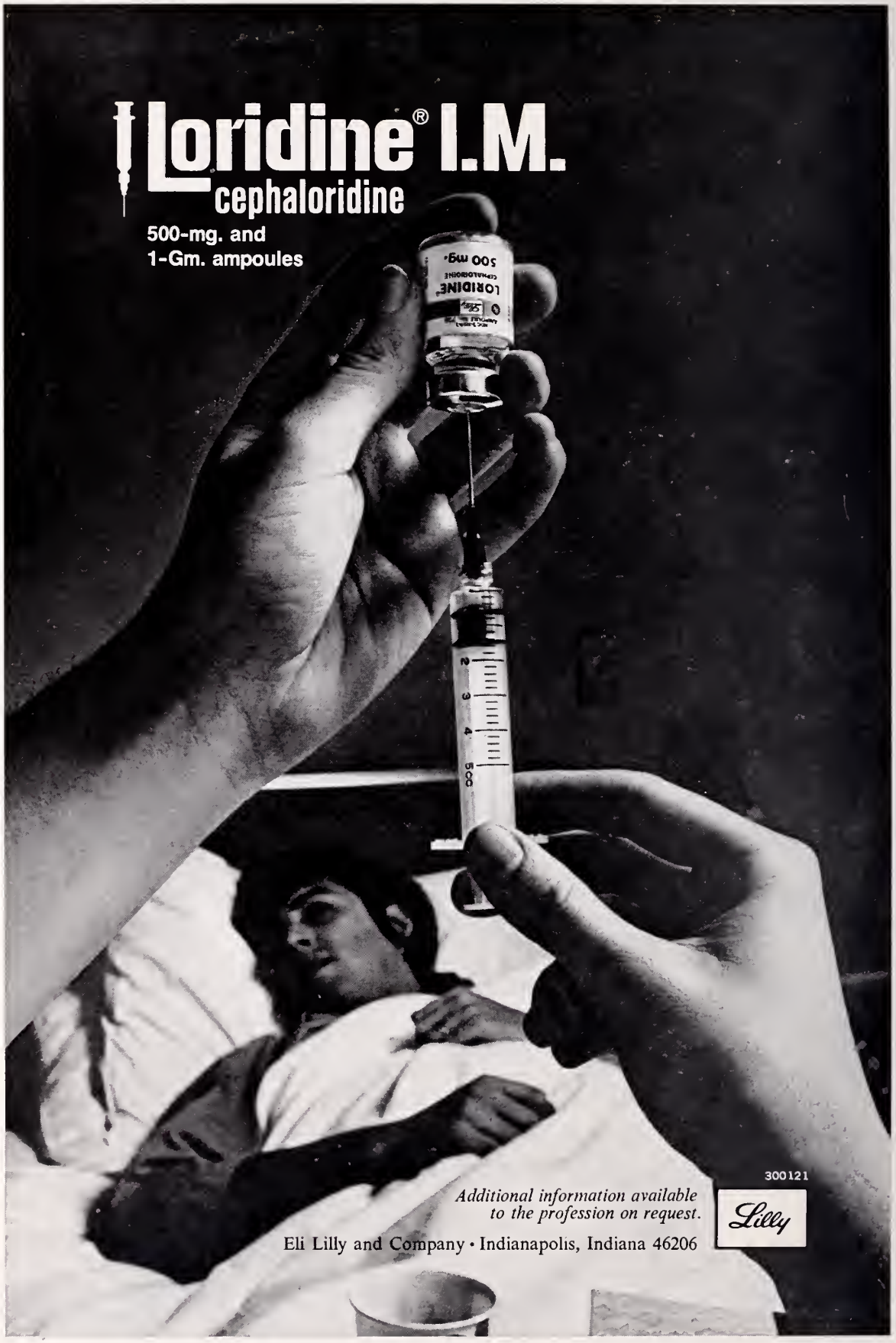
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Gaucher's Disease

(Case Report)

Cordell A. De La Pena, M. D., and Lawrence H. Mills, M. D.

In 1882, Phillipe Charles Ernest Gaucher,[1] a French dermatologist, presented a thesis to the Faculty of Medicine, in Paris, entitled, "De 1 'epithelioma primitif de la rate: hypertrophic idiopathique de la rate sans leucemic."

In this paper he reported on a patient in whose case there was chronic progressive splenohepatomegaly associated with skin pigmentation. The splenic pulp of the patient was replaced by sheets of large, pale cells. At first, he considered these peculiar cells in the spleen as evidence of a primary neoplasm and labelled it "primary epithelioma." Later, however, he suggested and recognized the disease as a major systemic process involving connective tissue proliferation associated with enlargement of parenchymal cells.

Schlaugenhaufer,[2] in 1907, recognized the condition as a diffuse systemic disease of the lympho-hematopoietic system. Marchand,[3] in the same year, after a number of investigations, indicated that these large pale cells consisted of a material that was lipoid in nature.

The Authors

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It was not until 1929 that Lieb[4] finally isolated the true composition of these cells. He discovered large amounts of cerebroside and kerasin. Then it was Philippart,[5] in 1964 who, in the process of studying the main splenic glycolipid, showed that the basic metabolic defect is a lack of the glycolipid-splitting enzyme leading to the accumulation of cerebroside kerasin.

The accumulation of cerebroside kerasin takes place mainly in the cells of the reticulo-endothelial system, producing an appearance so

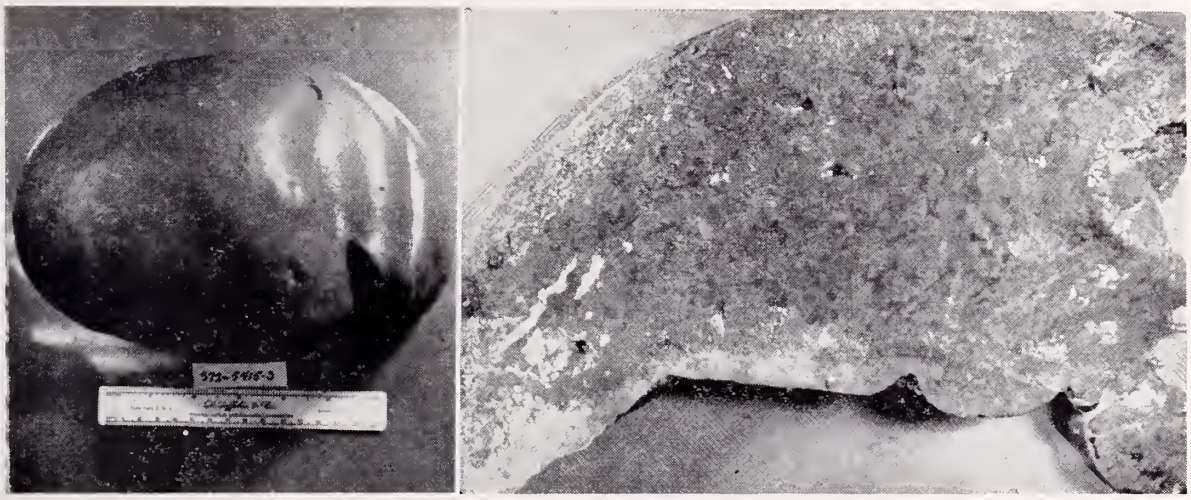

Figure 1. At left, enlarged spleen—gross weight 1650 grams; right, cut surface of spleen showing a reddish-purple granular appearance.

unique that they have been formally designated as "Gaucher cells." The increasing mass of these cells is responsible for most of the clinical manifestations of the disease.

Case Report

The patient is a 32-year-old white female of Anglo-Saxon origin. She was admitted to the hospital because of generalized body weakness, marked pallor, easy bruising, and an enlarging abdominal mass.

The past history showed six previous hospital admissions. In 1958 and 1961, hospital records show admissions for delivery of full term uterine pregnancies. On both of these occasions, the blood picture showed hematocrit readings of 27 and 32 mg. per cent. The first delivery was complicated by a perineal hematoma at the episiotomy site. The succeeding delivery was unremarkable.

The third hospital admission was in 1962 when the patient was admitted and treated conservatively for pelvic pain which was diagnosed as due to salpingitis. On this admission, because of hemoglobin levels of eight and nine Gm. and hematocrit readings of 28 and 30 mg. per cent associated with 2+ anisocytosis and hypochromia, she was said to have microcytic hypochromic anemia. The fourth hospital admission was in 1963 when she was admitted for an oophorectomy following a tentative diagnosis of pelvic inflammatory disease.

Pathological examination of the ovaries showed no significant findings. Hematological studies at this time again showed hemoglobin and hematocrit levels indicative of anemia, and the peripheral blood smear was again suggestive of microcytic hypochromic anemia. On this admission, x-ray studies showed evidence of stones in the gallbladder.

The fifth hospital admission was in 1967 when she was admitted for pain in the right upper abdominal quadrant associated with ingestion of fatty foods. This complaint and previous findings of stones in the gallbladder necessitated a cholecystectomy. Pathological examination did show chronic calculous cholecystitis. Again, hematological examination showed hemoglobin of 10 Gm., white blood count of 4,500, and a hematocrit of 30 mg. per cent. The peripheral blood smear again showed hypochromia and anisocytosis.

The sixth hospital admission was in January 1972 when she was admitted for delivery of a full term uterine pregnancy. On this hospital admission, it was discovered that her spleen was enlarged. Again, the peripheral blood picture showed hemoglobin of 7.8 Gm. and a hematocrit of 28.7 mg. per cent. A bone marrow puncture was performed, and it was suggested that the cause of the anemia was due probably to iron deficiency. Serum iron studies were carried out but these, however, proved normal.

On this sixth hospital admission, physical examination showed large ecchymotic areas of the upper and lower extremities. Physical examination on the present hospital admission showed a well developed, well nourished, extremely pale, white female with areas of punctate brownish discoloration over both cheeks of the face. Examination of the heart and lungs showed no pertinent findings. Palpation of the abdomen disclosed a markedly enlarged spleen extending down to the region of the umbilicus. Neurological examination showed no significant alterations. The admission diagnosis was "Banti's disease."

Laboratory workup on this admission showed a hemoglobin of 7.9 Gm., a hematocrit of 21.7 mg. per cent, white count of 4,900, and a peripheral smear showing anisocytosis and poikilocy-

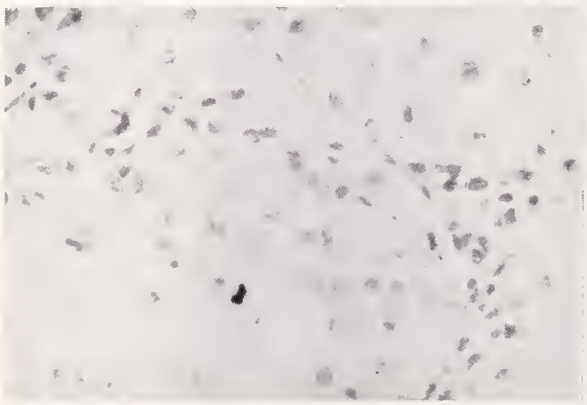

Figure 2. Microscopic picture—spleen high power—showing complete replacement with sheets of lipid cells. Note fibrillar cytoplasm and small eccentric nuclei.

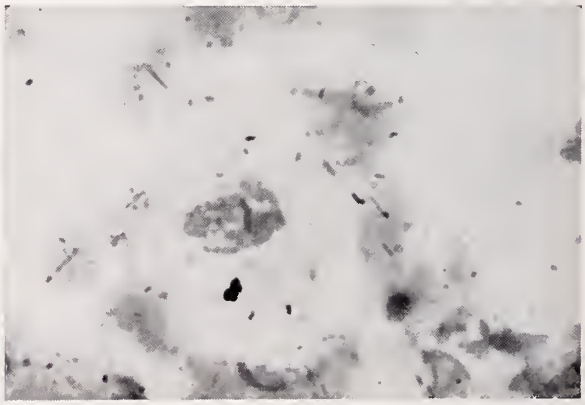

Figure 3. Bone Marrow Smear—showing typical Gaucher histiocyte.

tosis. Examination of platelets showed normal morphology on examination of the peripheral smear. Serum iron and serum iron binding capacity studies were within normal range. A splenectomy was carried out on the second hospital day. The spleen weighed 1,650 Gm. and measured 37 x 15 x 10.0 cm. The capsule was smooth, glistening, and reddish-purple. On section, the cut surface was granular and homogeneous reddish purple (Figure 1). Microscopic examination of a representative splenic section showed the entire parenchyma replaced with broad sheets of lipid cells. These cells had a characteristic fibrillar pale-staining cytoplasm and small nuclei with clumped chromatin (Figure 2). Our initial diagnosis was splenomegaly consistent with Gaucher's disease. We requested a bone marrow examination, skeletal survey and acid phosphatase determination. Because the patient was a female, we did not request L-tartrate inhibition of acid phosphatase. Bone marrow smears showed typical "sky-blue histiocytes" scattered among the hematopoietic cellular elements (Figure 3). The femoral bones bilaterally exhibited marked thinning of the cortices associated with medullary expansion (Figure 4). Serum acid phosphatase was elevated at 1.34 B.L.U.

Discussion

Gaucher's disease is considered an uncommon but not rare disorder, with well over 300 cases reported in the literature since 1882.[6] The disease manifests itself in two general forms: the more acute and fatal infantile type and the chronic adult variety. Nearly all patients afflicted with the disorder share certain common features: hepato- or splenomegaly, or both, the presence of Gaucher's cells in bone marrow aspirates, and abnormally high non-tartrate-inhibitable serum acid phosphatase.[7] The latter differentiates it from the prostatic enzyme, the activity of which is inhibited by L-tartrate.[8] When seen in the age group of our patient, we can feel certain that we are dealing with the chronic adult form because in the infantile variety the course is rapid and malignant and death usually occurs in the first year of life. Neurological symptoms characterized by hypertonia and opisthotonus are common in this variety, that is, the infantile form.

In contrast, the clinical course in the adult form as seen in our patient is, although progressive, compatible with life for many years. In this form, the disease may become apparent in childhood or early adult life. Our patient fits well into the picture when we review the literature and when we see that at age 18 years she manifested anemia during pregnancy and a hematoma following an episiotomy. The patient's anemia continued throughout the years until splenomegaly finally became apparent. The family history was reviewed, and we found no evidence of the disease in ancestors and siblings. It is too early to tell whether or not the patient's offspring will be afflicted with the disease. It has been suggested that the disease becomes increasingly

Figure 4. X-ray of femur showing medullary expansion with cortical thinning.

severe in succeeding generations.[9] Other studies, however, do not indicate this.[10] There is evidence that the frequency of miscarriage and neonatal death is increased in women affected with Gaucher's disease. Fortunately for our patient, she had three uneventful pregnancies and deliveries. The treatment usually is only of supportive nature and splenectomy being indicated when signs of hypersplenism appear or there is danger of splenic rupture due to size. There is no evidence to indicate, however, that splenectomy will alter the course of the disease. The prognosis in the case of our patient appears very good, and unless death comes by some other intercurrent disease, it could be expected that the course of her Gaucher's disease will extend over many, many years.

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The authors wish to acknowledge with thanks the assistance of the following physicians in the preparation of this paper: Drs. J. D. H. Wilson and Karl A. Lustig, Radiology Department; and Drs. Herman Fischer and Richard F. Fiester, Pathology Department, United Hospital Center, Inc., Clarksburg, W. Va.

A list of references may be obtained by writing The Journal.

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Effect of Ultraviolet Light on The Skin

Gabriel Al-Hajj, M. D.; Amanollah-Shafee, M. D.; And E. Schrae La Plante, M. D.

The action of ultraviolet light on skin is obviously complicated since it involves different layers which absorb radiation differently. Furthermore, the effect of radiation is a function of the dose as well as the penetration of different wave lengths.

The formulation of the quantum concept has been a major advance in photochemistry. When one studies the action of ultraviolet radiation on living systems, one is really studying a photochemical reaction or chain reaction set off by that physical agent, the first reaction being the capture of a quantum of radiant energy by some atom or molecule in the system.

It is now generally recognized by the biologist that a particular region of the ultraviolet spectrum extending from 0.32 to shorter wave lengths is responsible for the biologic phenomena produced by ultraviolet light. Gates, in 1928, suggested that the light absorber is nucleic acid. At present, the majority of the effects of ultraviolet light studied have nucleic acid as the light absorber, but there is no doubt that ultraviolet radiation from the same general spectral region may act on more than one type of substance in the living cell and hence it cannot be assumed that these effects always have the same basic mechanism.

Erythema Formation

The most noted sign of ultraviolet radiation is the erythemal reaction in the skin. Such reddening is due to enlargement and engorgement of the minute vessels in that part of skin nearest to the epidermis. The erythema reaches a maximum and then begins to fade. Also, it appears only after a latent period, hence differs from a heat erythema.[1]

The vascular response to ultraviolet injury is characterized by vasodilation and increased blood flow, increased permeability and cellular exudation, particularly of neutrophil leukocytes. A striking feature of these phenomena is that they appear to have a latent period that may last from two to ten hours.[7, 8]

The mechanism of vascular damage is not yet definite. In animals, a diphasic response is observed.[4, 5] Kinins have been implicated.[6] There was no evidence of histamine release. Serotonin, however, is suspected to be in some way connected with the process in the skin after ultraviolet irradiation.[17, 18]

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Effect on Skin Collagen

Collagenolysis is influenced by sex, exposure to solar irradiation, and a constitutional factor.[15] Shuster studied the effect of ultraviolet irradiation on collagen fractions *in vitro* as well as *in vivo* and was able to demonstrate a considerable decrease in saline and citrate eluted fractions of collagen after exposure to ultraviolet light.[2, 3, 16]

Effect on Melanogenesis

The familiar pigmentation which follows exposure to solar radiation or to ultraviolet light from artificial sources is known to involve two distinct photobiological processes, the first being primary melanization consisting of an erythemal response followed by formation of new pigment and the migration of melanin granules. The second process, called immediate pigment darkening (IPD), starts without any latent period and appears to be oxygen dependent.

Runge[13] suggested that melanoprotein molecules may be involved in inducing IPD. Miller-Milinska[9] studied the quantitative response of the melanocytes to ultraviolet light and showed a decrease in number of melanocytes after exposure, associated with an increase in size of the cells. Pathak,[10] however, found no significant increase in the density of melanocyte population, but there were morphologic changes indicating increased functional activity. Tyrosinase activity was found to be enhanced after 72 hours. Quevedo[11, 12] found an increased number of Dopa reactive epidermal melanocytes upon repeated exposure of the skin of the human buttock

to ultraviolet, whereas non-irradiated melanocytes were highly variable in Dopa reactivity. This supports the view that normally amelanotic melanocytes of the buttock become melanogenic in response to ultraviolet light. Seigi's work indicates that melanin protects enzymes from the ultraviolet light inactivation *in vitro*.

Effects on Epidermis

Scaling of the skin results from moderate sunburn. Stratum corneum thickening has been a feature of the epidermal response to ultraviolet exposure. Nix[21] studied the ultrastructure of stratum corneum after exposure at intervals. He described a distinct parakeratotic zone with large spheroidal, incompletely keratinized cells. Nuclei were retained. He also noted a cell possessing a large dendrite-like process and melanin which may be a melanocyte. Ogura[22] studied the histological and biochemical changes of rat epidermal nuclei after chronic exposure to ultraviolet light and found DNA content to be considerably decreased.

Ultraviolet Light and Carcinogenesis

When the idea was put forward at the turn of the century, much necessary information was not available. Since then, the parts of the picture have been brought together in a very satisfactory manner.

Blum[23] discussed the subject from many aspects. He found it difficult to deny the cogency of the proposition that the ultraviolet portion of sunlight is a causal factor in human cancer. Skin cancer has been correlated with fair skin plus degree and intensity of sun exposure in many studies.[24, 25] Basal cell, squamous cell as well as Melanomas have been reported to be associated with ultraviolet light exposure.[26, 27, 28, 29]

The pathogenesis of ultraviolet carcinogenesis is being studied along the lines of DNA synthesis. Recently two types of post ultraviolet DNA synthesis have been described, namely, repair and post ultraviolet semiconservative DNA replication. In patients with Xeroderma pigmentosum a defect has been found in removal of ultraviolet-induced Pyrimitive dimers which may lead to a high frequency of mutations and subsequently mutiple skin cancers. Epstein postulated, however, that not lack of DNA repair, but faulty DNA repair and subsequent errors in post ultraviolet semiconservative DNA replication lead to skin cancer due to an increased frequency of malignant change through mutation.

Black[19] obtained normal skin from surgery and in a controlled experiment was able to demonstrate both 7-KetoCholesterol and cholesterol, i.e., Alpha oxide as constituents of ultraviolet irradiated skin. Cholesterol alpha oxide has been shown to be carcinogenic both in rats and mice. This was the first time a carcinogenic compound was demonstrated in ultraviolet irradiated human skin.

Summary

Although the sun is essential for life, from it man cannot save his skin. He will suffer from an erythematous exposed area each time he tries to enjoy the sun. His skin will age faster, will become darker, and if he lives long enough, cancer of the skin may terminate his days under the sun.

A list of references may be obtained by writing The Journal.

One touch of nature makes the whole world kin.

SHAKESPEARE

Medical Grand Rounds

From the West Virginia University Medical Center

Edited By

Raymond B. Weiss, M. D.
Assistant Professor of Medicine

Streptococci And Streptococcal Diseases

Albert S. Klainer, M.D., Professor of Medicine; Chairman, Division of Infectious Diseases, West Virginia University Medical Center.

Streptococci are gram-positive cocci that occur characteristically in chains of varying length. When viewed with the light microscope, they appear as typical spherical cocci; but electron microscopy has shown them to be lancet-shaped and arranged in chains due to retention of cell wall material after cell division.

Streptococci are widely distributed in nature; some are part of the normal flora of man and animals, whereas others cause disease either by direct infection or by eliciting an immunopathologic reaction in the host.

Classification

Streptococci are classified by their hemolytic reaction, by group specific carbohydrates, and by type specific proteins.

Hemolysis. Streptococci may be classified by grading the degree of hemolysis occurring around colonies on a blood agar plate (Table 1). Characterization of hemolysis is merely a crude method of classifying streptococci. The degree of hemolysis may vary depending on the strain of streptococcus; the type of blood used (sheep blood is best to demonstrate beta-hemolysis); and whether colonies grow on the surface of, or deep within, the agar. In general, beta-hemolytic streptococci are more invasive than those which manifest alpha-or gamma-hemolysis.

Grouping. Streptococci also are classified by *group specific* carbohydrate antigens in the cell wall. These *C-carbohydrates* are the basis for the Lancefield classification. Although many groups of streptococci may exist, thirteen are of significance to man and animals. Groups are designated in capital letters (Table 2). There is no evidence that C-carbohydrates play a role in acute suppurative human disease; their role in the non-suppurative complications of streptococcal infection, i. e., acute glomerulonephritis and acute rheumatic fever, is still questionable.

Typing. Streptococci are *typed* by the nature of the type-specific *M-proteins* contained in their cell walls. Approximately 50 immunologic types have been described. Types are designated by numbers or proper names, and certain types are associated with an increased incidence of certain diseases, e.g., Red Lake strain and types 4 and 12 are nephritogenic strains, i.e., acute glomerulonephritis has been seen with increased frequency following infection with these types. Ordinarily five or six types are present in a community during interepidemic periods; the occurrence of a new predominant type generally heralds the onset of epidemic streptococcal infection. M substance is a determinant of invasiveness; the more M substance, the more invasive the organism. This relationship probably reflects the fact that M-protein is antiphagocytic. Anti-body developed against M substance is bactericidal (protective) and is type specific; this is in contrast to antibody against the group specific capsular polysaccharide which is not protective.

The classification of streptococci can be summarized by using a typical organism as an example:

Group A,	type 12,	beta-hemolytic streptococcus
Group-specific carbohydrate	type specific M-protein	hemolytic reaction around colony

Cultural Characteristics

Streptococci are more fastidious than staphylococci and grow best on blood agar. Streptococcal colonies are greyish, translucent, small

(1-2mm. in diameter) colonies which are non-pigmented. Colonial morphology is similar for alpha-, beta-, and gamma-hemolytic streptococci. Streptococcal colonies appear similar to those of pneumococci, but can be differentiated by the solubility of the latter in bile salts.

Many strains of hemolytic streptococci produce capsules. In Group A streptococci, the capsule is composed of hyaluronic acid. Capsules are demonstrable only in very young, two to four hour cultures.

On blood agar plates, streptococcal colonies appear as one of three colonial types: (a) mucoid (glistening, moist colonies formed by strains which produce large capsules), (b) matt (rougher, drier colonies which are probably dried out mucoid colonies and do not reflect the presence of M-protein as previously thought) and (c) smooth (small, glossy colonies formed by non-encapsulated streptococci that usually produce large amounts of M-protein). In general, colonial morphology of Group A streptococci is related to the hyaluronic acid capsule and not to M-protein.

Extracellular Products

Group A streptococci produce a wide variety of extracellular products many or all of which play a role in the pathogenesis of streptococcal diseases:

Streptolysin O. A hemolysin so designated because it is oxygen-labile (O) and is reversibly inactivated by atmospheric oxygen. Antibody to it (anti-streptolysin O titer) is used as a retrospective aid in the diagnosis of recent streptococcal infection. Streptolysin O may be cardiotoxic.

Streptolysin S. A serum soluble (S) hemolysin which probably is a poor antigen and, therefore, not utilized as a diagnostic parameter of streptococcal infection.

Leukocidins. Labile factors which, in high concentration, are toxic to white blood cells. These toxins, of which there are two, may be identical to the streptolysins.

Enterotoxin. An exotoxin which, if ingested, results in streptococcal food poisoning which may present with sore throat, nausea, vomiting, diarrhea and a scarlet fever-like rash.

DPN'ase. An enzyme, diphosphopyridine nucleotidase (also DNA'ase or nicotinamide adenine dinucleotidase), which liberates nicotinamide from DPN. It may kill leukocytes which phagocytize strains of Group A streptococci which elaborate this enzyme. Nephritogenic strains in particular produce DPN'ase, but there in no obvious relation to the production of post-streptococcal glomerulonephritis. Anti-DPN'ase antibodies are found frequently in the sera of patients with recent streptococcal infection. DPN'ase may be cardiotoxic for animals and has been thought to play a role in the acute necrotizing myocarditis occasionally developing after acute Group A, beta-hemolytic streptococcal pharyngitis.

DNA'ase. These enzymes depolymerize deoxyribonucleic acid (DNA). There are three immunologically distinct types, A, B, and C, which can be differentiated by electrophoresis. Although streptococcal DNA'ases are not cytotoxic because they cannot penetrate the cell membranes of living mammalian cells, depolymerization of DNA in pus may help to liquefy

TABLE 1.

Classification of Streptococci by Hemolysis on Blood Agar

Type of Hemolysis	Appearance of Zone of Hemolysis	
	Gross	Microscopic
alpha	green	some intact red blood cells; green color due to presence of a reduction product of hemoglobin
beta	clear	no intact red blood cells present
gamma	no zone of hemolysis; red blood cells intact	

TABLE 2.

Classification of Streptococci by Group-specific Carbohydrate (Lancefield Classification)

Group	Significance to Man and Animals
A	Cause 95 per cent of human streptococcal infections; most are beta-hemolytic.
B	Cause mastitis in cows, but some cases of bacteremia and meningitis have been reported in human neonates.
C	Commonest group found in animals; can result in scarlet fever in man.
D	Found in dairy products; have been seen as increasingly important pathogens in man, especially as a cause of urinary tract infections and endocarditis; may be beta-hemolytic.
E	Found in milk; a rare cause of pharyngitis in man.
F	Have been isolated from the respiratory tract of man.
G	Have been isolated from the upper respiratory tract of humans with scarlet fever and have been shown to be a cause of urinary tract infection in dogs; these organisms appear as very tiny colonies which are occasionally beta-hemolytic.
H,K	Have been found in the human upper respiratory tract.
L,M	A cause of genital infections in dogs.
N	Occur in dairy products.
O	Occasional inhabitant of the respiratory tract of humans.

viscous purulent exudates. An enzyme preparation containing streptokinase and streptococcal DNA'ase *(streptodornase)* is commerically available for use as an enzymatic debridement agent.

Streptokinase. An extracellular product of streptococci that stimulates lysis of human blood clots by catalyzing the conversion of plasminogen to plasmin, a protease. Antistreptokinase antibodies are formed during infection with the Group A streptococci.

Proteinase. An enzyme that is capable of destroying M-protein and other extracellular streptococcal proteins. It is active only at a pH of five and one-half to six and one-half, and its role in the pathogenesis of streptococcal infections is unclear although it can cause a necrotizing myocarditis in laboratory animals after intravenous administration.

Hyaluronidase. An enzyme which lyses hyaluronic acid and, therefore, may alter the antiphagocytic properties of the streptococcal capsule. This enzyme was originally called "spreading factor" because of its ability to lyse the ground substance of connective tissue; whether or not this is of significance in the "spread" of streptococcal infection or in the pathogenesis of rheumatic fever is unclear. It is of interest, however, that human and streptococcal hyaluronic acids are chemically indistinguishable and that the Type 4 streptococcus, a strain which produces no hyaluronic acid, has not been associated with acute rheumatic fever.

Erythrogenic Toxin. Erythrogenic toxin causes the rash of scarlet fever. There are at least three antigenically distinct erythrogenic toxins, Types A, B, and C, produced by different strains of streptococci.

Erythrogenic toxins are produced by Groups A, C, and G streptococci and some staphylococci. Although the exact mode of action of the erythrogenic toxins is not clear, they appear to act as capillary poisons, causing capillary dilatation (resulting in the striking erythema of the skin in scarlet fever), congestion in the capillary bed (resulting in punctate red spots in the skin), and increased capillary fragility (the cause of the petechiae and the bleeding lines in the skin observed in scarlet fever).

1. *Dick Test.* When erythrogenic toxin is injected into the skin of a susceptible person, it results in a localized area of erythema which is maximal at 24 hours (positive Dick Test), indicating the absence of circulating antitoxin; in an immune person with circulating antitoxin, no erythema occurs (negative Dick Test).

2. *Schultz-Charlton Test.* Intradermal injection of homologous antitoxin at the height of the scarlet fever rash causes local blanching. This has been used to help document that an acute erythema is scarlet fever.

Streptococcal Diseases

Disease due to infection with the streptococci is the result of one or a combination of events: (1) Local injury at the site of invasion, (2) Absorption of toxic materials elaborated by proliferating streptococci at the site of local injury and (3) Contiguous or systemic spread. Streptococci usually are transmitted from man to man by carriers, active cases, fomites, and via the air when the density of streptococci in the air reaches a critical level.

Pharyngitis. Group A, beta-hemolytic streptococcal pháryngitis is the most common streptococcal disease and by far the most common of the bacterial pharyngitides. It is extremely difficult to diagnose streptococcal pharyngitis by clinical appearance alone. Typically it is characterized by sore throat, fever, leukocytosis and localized tender lymphadenitis; the pharynx appears magenta (purplish-red) in color and frequently is spotted with purulent exudate; the presence of pinpoint petechiae at the junction of the soft and hard palates and on the uvula is a helpful diagnostic sign. The tonsils, if present, appear large and boggy and also are covered with exudate which wipes off easily. The diagnosis is tentatively made by the clinical appearance but must be substantiated by demonstrating the organism in cultures of material obtained by throat swab. There is no relationship, however, between the severity of the pharyngitis and the number of organisms which can be isolated; in fact, no presently available cultural technique allows a 100 per cent recovery rate of the organism.

The suppurative complications of streptococcal infection in the pharynx result from spread upward, downward, inward, or out onto the skin. Upward spread results in sinusitis, otitis media, mastoiditis, meningitis, or brain abscess; downward, laryngitis, tracheitis, and pneumonia; inward, bacteremia, with subsequent metastatic infection to any organ; and out, paronychia, impetigo, cellulitis and erysipelas.

Scarlet Fever. Scarlet fever is a disease state due to infection, usually acute pharyngitis, with an erythrogenic toxin-producing strain of streptococci in a susceptible host. The rash is punctate and typically starts behind the ears and spreads to the rest of the body; the face usually is spared except for the cheeks, and circumoral pallor is

characteristic. The rash may be fleeting, or it may be very severe with petechiae and hemorrhagic cutaneous lesions. The tongue has the non-specific appearance of a strawberry due to large, red papillae protruding through a whitish coating. Desquamation of the skin is typical as recovery progresses.

Cellulitis. Cellulitis is an infection of the subcutaneous tissues most commonly due to infection with the group A, beta-hemolytic streptococci or straphylococci. It is characterized by localized pain, swelling, and redness which fades into surrounding normal skin.

Erysipelas. In contrast to cellulitis, erysipelas is an infection of the dermis without involvement of the subcutaneous tissue but with acute lymphangitis. The lesion is red, warm, and painful and is characterized by a slightly raised, serpentiginous border which is sharply demarcated from the surrounding normal skin. Streptococci can be recovered occasionally from the lymphatic fluid in the advancing edge of the lesion. Eighty per cent of erysipelas occurs on the face; it usually is bilateral and frequently involves the bridge of the nose and both cheeks. In some cases, erysipelas can spread from the face upward over the forehead and scalp and downward over the neck, giving the patient a "swollen head." In children, erysipelas of the abdominal wall can occur from infection of the umbilicus; genital infection can result from infection at, or shortly after, birth. Healing occurs from the center outward, and desquamation is common. Recurrence in the same or a different area is more frequent than with cellulitis.

Impetigo and Furunculosis. Impetigo is a primary superficial pyoderma characterized early by multiple discrete papulovesicular lesions of skin which later become crusted. Impetigo often pursues a chronic course with individual lesions lasting a week or longer and cutaneous infection persisting for weeks or months.

Furunculosis is an infection of hair follicles; folliculitis and carbuncles are anatomical variants of furunculosis.

Non-Suppurative Complications. The non-suppurative complications of group A, beta-hemolytic streptococcal infection are acute rheumatic fever and acute glomerulonephritis. Both are felt to be poststreptococcal immunopathological reactions in the host. The exact mechanisms whereby streptococcal infection leads either to rheumatic fever or glomerulonephritis have not been clearly elucidated.

Summary

Streptococci are the commonest cause of bacterial pharyngitis in man; in addition, they cause other suppurative disease and have been implicated in the pathogenesis of acute glomerulonephritis and rheumatic fever. An understanding of their microbiology and the mechanisms whereby they cause disease will provide a better appreciation of this group of microorganisms.

A list of articles and textbooks recommended for suggested reading may be obtained by writing The Journal.

Pedalling Rats Aid Arthritis Research

A University of Wisconsin researcher, using rats strapped into a bicycle-like device, has found that the amount of exercise applied to a leg changes bone size and mineral content affecting the strength of the bone.

Dr. Ali Seirig, a mechanical engineer at the UW campus in Madison, is studying the effects of stress on bone mineral content, the role of muscle fatigue in fracture, and the causes of wear in joints. He says an overload of exercise leads to damage in the joints because, like bone, cartilage increases in mineral content when placed under stress.

Too much exercise, according to Doctor Seirig, also causes a breakdown in synovial fluid—the lubricant in joints—which can cause cartilage to become worn. The breakdown that occurs is similar to that which occurs in overheated crankcase oil.

Doctor Seirig pointed out that "joint temperature may actually prove a good tool for measuring damage in living animal joints. This and the other techniques we have developed provide a tool for testing drugs and methods of treatment to avoid arthritis that comes from stress."—*National Society for Medical Research.*

Special Article

The Practicing Physician And The New Supplemental Security Income Program

L. F. McCoy, M. D.

On January 1, 1974, a large part of the public welfare program will move from state to federal administration. This will result in some increase in the dollar amounts received by each recipient and also in significantly different procedures and criteria for the determination of the disability status of applicants. The latter directly affects physicians. This article describes the main changes which will occur as we enter the new program.

The portion of the welfare program which is being federalized is the money grant to the indigent who are either aged, or too disabled to work. All social services remain as at present as the responsibility of the State Department of Welfare. This Department also continues as the agency for the money grant program for inidgent families with dependent children and for those other adults who are not aged, blind or disabled. Eligibility for the federalized welfare program, known as the Supplemental Security Income Program, requires a decision by the operating agency that the applicant is both indigent and additionally either aged, blind or disabled. The decisions as to the latter two categories (blind and disabled) require medical evaluations. The Federal Government has contracted with the West Virginia Division of Vocational Rehabilitation to develop the medical evidence and to make the decision as to the presence of blindness or of disability.

Most West Virginia physicians have some familiarity with the general approach to disability evaluation which the Supplemental Security Income Program will use. The Social Security Administration has for years contracted with the West Virginia Division of Vocational Rehabilitation to develop the medical evidence and to make the disability decision on applicants for the Social Security Disability Program. The operation of the Supplemental Security Income Program will have many similarities.

The Author

- **L. F. McCoy, M.D., Medical Director, West Virginia Division of Vocational Rehabilitation, The Capitol, Charleston.**

The procedure is to first obtain copies or reports of existing medical evidence such as from previous physician and hospital care. This is evaluated according to written criteria provided by the Social Security Administration as to what level of impairment warrants a decision of total disability. However, if the already existing medical data is not adequate to permit a decision, the Disability Determination Section of the Division of Vocational Rehabilitation arranges and pays for additional tests or consultations so that a decision can be made.

The Supplemental Security Income Program eligibility determination procedure will differ from the Social Security Administration Program in several important respects. The current Social Security Administration Program requires the disability applicant to produce the initial medical evidence to support his claim. The new Supplemental Security Income Program is, in general, dealing with a different type of applicant: the indigent. Generally he will be without resources to obtain the initial medical evidence. Supplemental Security Income procedures therefore permit our agency to authorize payment of a fee for reproducing or extracting relevant existing medical information from records when it will be useful in the disability decision and when there is a charge. We shall provide you with an authorization signed by the applicant and a description of the type of evidence needed when requesting existing medical information.

We are also authorized to arrange and pay for an initial medical evaluation of the applicant who has no medical evidence of record of value in support of his claim.

Children with Impairments

The Supplemental Security Income Program will differ from the current Social Security Administration Disability Program in another respect: for the first time we shall be making a disability decision with reference to children with impairments. The criteria used in adjudicating child applicants will depart substantially from those used for adults. We shall, also for the first time, be seeking evaluations by pediatricians. The validity of the inital criteria with which we enter the program is targeted for careful evaluation as these criteria are put to the test of attempted massive application.

Actually, the decision that a person is totally disabled such that he is unable to engage in substantial gainful work is based on two kinds of information: (1) the medical evaluation of his functional level, and (2) the nonmedical factors of work skills, educational attainment, and applicant age. Thus, a 31-year-old engineer with an amputated arm would presumably be found not totally disabled whereas a 56-year-old unskilled laborer with the identical impairment might be judged totally disabled. Because of the disability decision being a composite of medical and nonmedical factors the Division seeks from the medical examiner objective, quantified data on the client's impairment (e.g. forced expiratory volume, joint stability and range of motion) to the extent determinable rather than an opinion as to the existence of a total disability. It is true, however, that very severe impairment will result in a finding of total disability regardless of the nonmedical factors.

The Supplemental Security Income Program also resembles the current Social Security Disability Program in defining the disability component of eligibility as that which has or can be expected to be totally disabling for 12 consecutive months or longer or result in death. Eligibility will terminate if and when total disability ceases. Either physical or mental impairments may be the basis for the determination. The Supplemental Security Income Program will use the same criteria for deciding disability for adults as the Social Security Administration has been using in its disability program.

Estimated Number of Applicants

Our current estimates are that we shall be confronted with perhaps 800 -1,000 applicants per month in West Virginia who will need evaluation of impairments. Internal medicine (including cardiology), orthopedics, psychiatry, neurology and ophthalmology in that order constitute the most frequently needed fields in which evaluation is needed among these applicants.

In the handling of these applications there will be a compelling reason for both the agency and cooperating physicians to do their best to get their findings out promptly. Many persons brought to the point of indigency and total disability by an impairment will put off applying for relief with the hope that some other solution to their plight will appear. We may finally get their applications when they are on the brink of actually being without food, heating fuel or other real necessities. Although authority exists to make payments for up to three months on the basis of presumptive disability, long delays in qualifying this type of person for help who has fallen on hard times is particularly regrettable. We must all do our best to avoid this kind of needless suffering due to our collective slowness. Incidentally the five-month waiting period required between onset of disability and payment of benefits under the Social Security Disability Program does not pertain under the new Supplemental Security Income Program.

Importance of Disability Evaluation

Disability evaluation is understandably less appealing to most physicians than the main thrust of the profession: the diagnosis, management and ofttimes cure of the sick. Yet, like paying taxes, it is an indispensable component of the proper operation of our society. No one has yet found a better way to separate the helpless whom we want to help from the lazy for whom we want a different strategy.

The individual who can be vocationally rehabilitated must be identified from among those who do not need, or still cannot work after, services. The worker who has lost a portion of his capability because of an industrial accident needs to be appropriately compensated. Considering the costs of Medicaid, Welfare, Social Security and Black Lung payments, Workmen's Compensation, Rehabilitation and similar programs which start with the disability evaluation, our small state is annually spending one-fourth of a billion dollars based on disability decisions! Rather obviously those decisions cannot be better than the medical evidence on which they are mostly based. The state badly needs the quality participation of all of its physicians; each doing his share to get this large task done promptly and well. No one else can do this part of the job. Thus a rather astounding portion of government utterly depends on the medical disability evaluation as it attempts to be good government—fair and economical government.

Initial 'Bugs' Anticipated

Like in all rather massive new ventures we can anticipate confidently that this new Supplemental Security Program as laid out on the planning drawing boards will initially prove to have "bugs." The participating physicians will surely see some of these before the program administrators because of their perspective as examiners. The agency, of course, will want to promptly identify and try to eliminate such shortcomings. You will, therefore, be very helpful to this new program if you will take the time to communicate problems and suggestions to the administrators. Mr. Anderson Allen of 1206 Quarrier, Charleston (telephone 348-5340) is in charge of the Disability Determination Section. He will react to your suggestions as regards the state portion of the operation and will pass along to the Federal Government the information appropriate to the Federal program component. The writer also will be keenly interested in helping where he can to improve this program.

I'm sure you share with me a strong wish for this program to effectively accomplish what Congress intends. We are the people who hold the key. Let's register a success!

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Servic

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidi and Mortality Weekly Report,* the Advi ory Committee on Immunization Pra tices of the United States Public Heal Service presented recommendations the use of combination live virus vaccine The committee stated that:

- "Data indicate that antibody respon to each component of these combinati vaccines is comparable with antibody r sponse to the individual vaccines giv separately.
- "There is no evidence that a verse reactions to the combin products occur more fr quently or are more seve than known reactions to t individual vaccines (see pe tinent ACIP recommend tions).
- "The obvious convenien of giving already select antigens in combined for should encourage consider tion of using these produc when appropriate."

M-M-R*

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

MSD suggested immunization schedule for well babies	
Age	**Vaccine(s)**
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

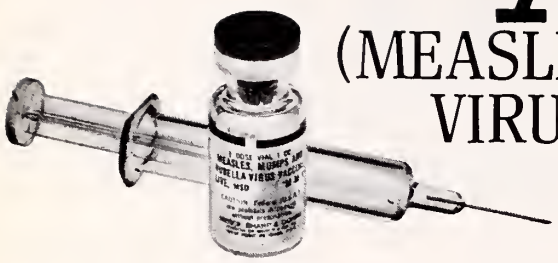
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; *do not give intravenously.* Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and protect *from light.* Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1–9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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Special Article

Medical Compassion*

W. Patrick Joseph, M. D.

I am grateful to the coordinators of this Investiture Service for the privilege of sharing with you some of my observations concerning our graduation. Our presence here is evidence that we have satisfied the academic requirements and technical skills necessary for the treatment of human illnesses.

Our experiences, however, have not been restricted to a rigid scientific approach to our responsibilities. In addition, we have learned the value of the physician's empathetic expertise in relation to his patients and since because such personal relationships are important to everyone in this auditorium—especially to those of us graduating this weekend—I choose to concentrate my remarks on the topic of human compassion.

I remember very vividly making daily rounds about eight months ago in a private hospital with my attending physician, and we stopped to see a middle-aged man recovering from pneumonia. After checking him briefly and talking with him awhile, he said, "You know, you two are the best damn doctors I've ever met." He went on to say that he had been hospitalized a number of times for various medical and surgical problems and had seen a doctor regularly as an out-patient, but never before knew what medications he was taking or why he was instructed to do something. More importantly, however, he felt that this particular doctor now cared about him as a person, rather than a case of pneumonia.

Well, that very brief, almost incidental conversation made a tremendous impression on me—for two reasons. First, I was very flattered that he felt that way about my attending and me, and secondly, I began to realize that there must be a great number of patients, just like him, who are very disappointed with medical care because they are treated as diseases rather than as people.

My feelings about this particular patient have stayed with me for the remainder of the year, and as I rotated through different selectives, I saw at times what I considered disgusting indifference or coldness to patients as people, even though the therapeutic regimen was excellent for a particular disease.

As I followed the charts on some of these people, I could see them objectively improving as their laboratory values returned to normal, but there still was something missing. Although these patients began to feel better physically, many were quite disappointed at the assembly-line type of treatment they had received; and at discharge, they returned for follow-up care not because they understood the importance of re-examination, but because they feared the unknown.

As I thought about my exposure to these people, and because I know most all of my classmates have seen similar patients and felt just as I did, I concluded that there is a new attitude—an element of compassion present in our class that had previously been lacking—and that this new attitude will return a missing dimension into medical practice.

I think my conclusion was premature and wrong. I think this attitude is not a new one, restricted solely to our class of younger graduates in general, but rather, I think this attitude of treating patients as people—people with illness—has been present in every graduating class since medical schools began. Furthermore, it appears more likely that throughout postgraduate training and practice that this something has been lost; that somehow, many doctors have become so involved in medical science that they have neglected the Art of Medicine.

To me, Medicine is an Art and a Science. Medicine is not just treating gram positive rods or an elevated uric acid, but it is treating patients

The Author

• **W. Patrick Joseph, M.D., a 1973 Graduate of the West Virginia University School of Medicine; Now Serving an Internship and Residency at Highland General Hospital in Oakland, California.**

*Address delivered during the Investiture Service of the West Virginia University School of Medicine on May 19, 1973 in Morgantown.

as individuals with disease. Consequently, in any health care delivery system, despite its mechanics, we must always realize that the foundation of medicine is one individual working with, learning from, and trying to help another individual.

My plea is that each of us graduating this weekend retains the human compassion that we have now for patients; that as we continue in our education, we do not lose the Art of Medicine and do not begin treating human beings as examples or statistics.

I'm not sure just where the pitfall has been, or at what point in education that so many enthusiastic and sincere doctors changed from individuals offering a service to merchants selling a product. It may be temptation to acquire leisure time or an outright lust for money that will cause some of us to lose compassion, and then medicine quickly evolves into a cold business—and believe me, it's very easy to sell a product in such great demand.

It seems that it all boils down to the character of each of us, our own constitutions, and whether or not we will continue as we feel today or degenerate into an emotional apathy. I'm sure we all know, from our own faculty and friends, doctors who fit into each category, and I'm sure we all share the same respect for those ones who always consider the patient first, as an individual.

I must emphasize, however, that it is going to be even harder for us to keep our idealism than it was for those graduates of 20 years ago because of the intense social and political pressure on the field of medicine today. We have all grown to appreciate the rapid pace at which medicine is changing, and at this time, can only speculate as to the final result, but no forthcoming law, no new social structure, and no organizational change can ever compel human compassion between a doctor and his patient. In fact, many proposals for efficiency-based medical superstructures, which indeed may develop, will certainly attempt to depersonalize the practice of medicine.

I will avoid my political opinions in this talk, but I can say that whatever the result, each of us must constantly be aware of his own feelings; only then will we be able to retain human love and compassion, respect for mankind, and interest in patients as people.

Doing Away With 'Hot Dogging'

"Hot Dog" skiing is spectacular to look at—but it can be the last memory of motion for some who do it. During the 1972-73 season, ski stunting caused three cases of quadriplegia (paralysis of arms and legs) and one of paraplegia (leg paralysis), the Colorado Medical Society said. Meeting in Colorado Springs recently, the society urged ski areas to outlaw commercial sponsorship of competitive events featuring aerial somersaults on skis and other stunts.

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Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

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Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

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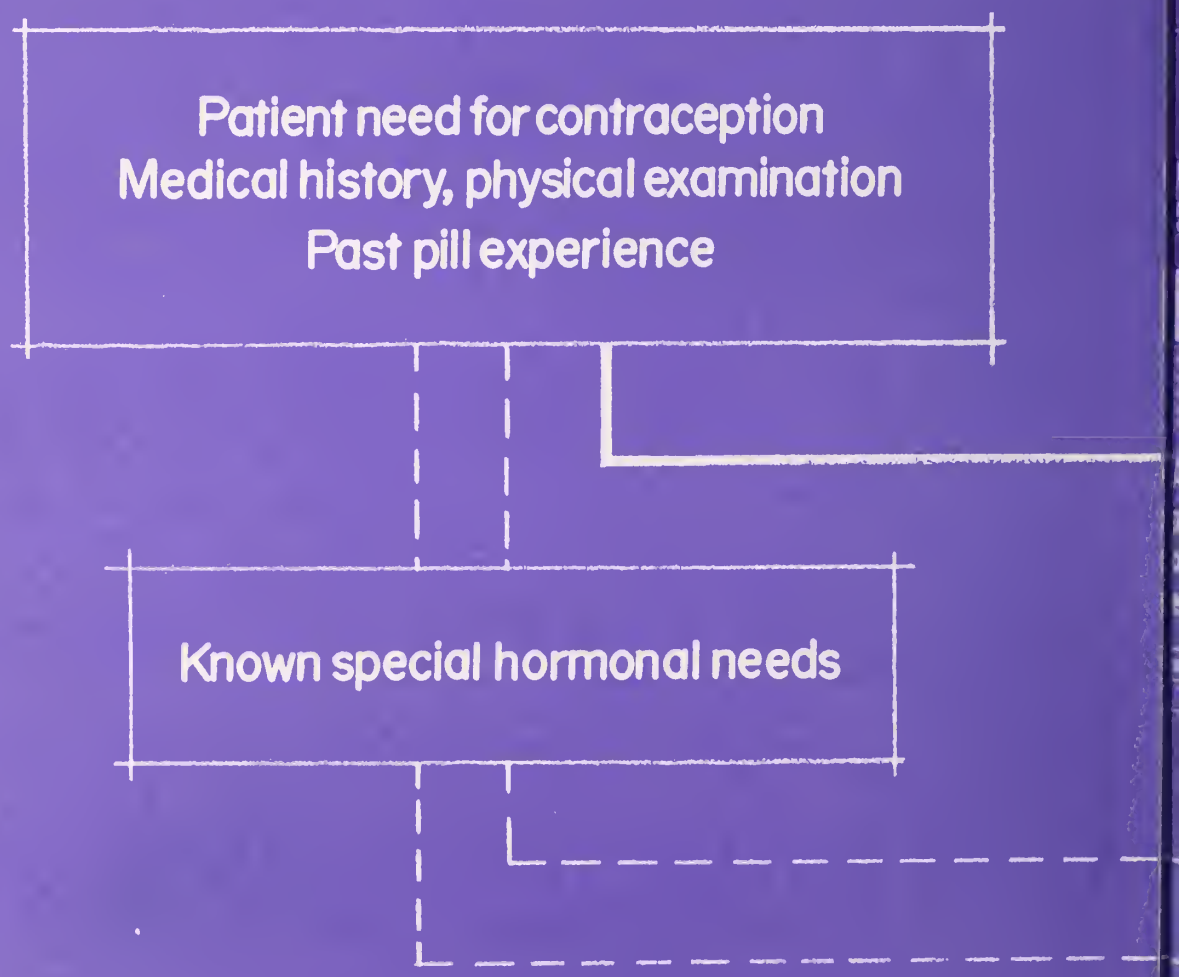

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imarily on animal studies.

Note: Oral contraceptives are complex medications. As with all medications they should be prescribed with discriminating care, and only after reference to full prescribing information. For brief summary of prescribing information, please see next page.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Prac. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-65 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Green, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epider *90*:365-380 (Nov.) 1969.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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brand of norethynodrel with mestranol

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are pleased to announce

"The Seventh Mid-Winter Clinical Conference"

at the

Heart-O-Town Motor Inn
Washington and Broad Streets
Charleston, West Virginia

8 P.M. Friday, January 18
10 A.M. and 1:30 P.M. Saturday, January 19
10 A.M. and 1:30 P.M. Sunday, January 20

THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY EVENING, JANUARY 18, presentations will include Professional Standards Review Organizations (PSROs) and a session open to the public on the "battered child." A medically oriented battered child program will follow SATURDAY MORNING, JANUARY 19, with these other scheduled subject areas: SATURDAY AFTERNOON, asthma, diabetes, heart disease and hypertension, diuretic management; SUNDAY MORNING, JANUARY 20, cancer chemotherapy, antimicrobial therapy and arthritis; and SUNDAY AFTERNOON, obstetrics and gynecology, urology and chemotherapy of the venereal diseases.

THE FACULTY will include outstanding specialists in their fields from various educational and other settings, both outside and from within West Virginia.

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M.D., and Joseph T. Skaggs, M.D., both of Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents; and will include admission to a group buffet luncheon on Sunday, January 20. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians planning to spend one or more nights in Charleston should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters inn setting aside rooms for registrants.

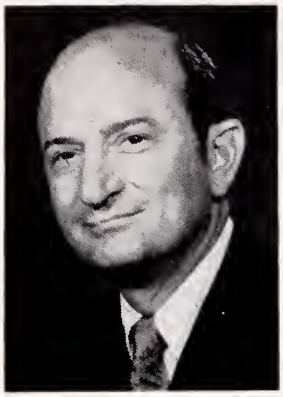
FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. Va. 25324.

Please register me for the Seventh Mid-Winter Clinical Conference in Charleston, W. Va., January 18-20, 1974. My $15 registration fee is (is not) enclosed.

I will attend sessions at 8 P.M. Friday, January 18 ..... 10 A.M. Saturday, January 19 ....., 1:30 P.M. Saturday ..... 10 A.M. Sunday, January 20 ..... 1:30 P.M. Sunday ..... all sessions .....

Name (please print) _____ *Specialty* _____

Address _____ *City* _____



A message from . . .

The President

THE HOLIDAY SEASON

During the Holiday Season it is appropriate for one to make it a point to greet friend and foe alike with a smile and with best wishes for whatever might lie ahead in the next twelve months.

With this in mind, I shall not attempt to elaborate on any of the tremendous and baffling problems we must face during the year 1974.

Simply and humbly, the members of my family join me in thanking you for your many kindnesses and wish for each of you and your families a Merry Christmas and a Happy New Year.

Tom McCoy

A. Thomas McCoy, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

MARK YOUR CALENDAR RIGHT NOW!

West Virginia's physicians need, right now, to mark next January 18, 19 and 20 very clearly on their calendars. Those are the dates for the Seventh Mid-Winter Clinical Conference, to be held in Charleston under sponsorship of the West Virginia State Medical Association and several other organizations.

From Friday night, January 18, non-scientific programs on Professional Standards Review Organizations (PSROs) and the battered child, to Sunday afternoon's emphasis on obstetrics, gynecology, urology and venereal disease, the schedule will offer an educational bonanza.

This will be the second year in which the old one-day Mid-Winter Conference on Chest Diseases has been expanded into a composite type of program designed particularly to give the practicing physician some solid, down-to-earth help in his every-day work.

The Medical Association's Committee on Medical Education and Hospitals, and others vitally interested in such programs, have insisted for several years that West Virginia needs in the worst way fewer, but bigger and better, clinical sessions each year.

This position recognizes a professional paradox —the desire and need, on the one hand, of physicians for increased educational opportunities to help them provide the quality of care to which they are dedicated; and the very real problem, on the other hand, of finding time in increasingly busy practices to take advantage of such opportunities.

The new Mid-Winter Conference format is a solid step toward resolving this paradox. Reaction of those physicians who attended the January, 1973, sessions was among the most positive on Medical Education Committee record.

The physicians went home satisfied their valuable time was well spent. They said so in completing a questionnaire that always has elicited the most critical kind of reaction. Sponsors of the 1974 program are confident it will leave participants with an even better feeling.

WEST VIRGINIA HEART ASSOCIATION RESEARCH GRANTS

For a number of years the West Virginia Heart Association has set aside a certain amount of money for grants for research projects. In the beginning the amount of money available was small, but of recent years the quantity has distinctly increased; for example, at present (1972-1973) approximately $35,000 is available. The size of the grants allotted are not large, and vary from $1,000 to $3,000. As a result, it is possible to support from 10 to 15 projects yearly. If the project is not

completed within a year, it is often possible to extend the time of the grant, and in some instances additional funds may be added.

Although the grants are of especial value to young workers, who are not well enough established to secure grants from other sources, they are also useful to more experienced scientists. There has been a marked reduction in grants available from the National Institutes of Health and kindred sources. It is not in the province of this essay to criticize the attitude of the Government for making less money available for scientific workers. In fact, it is thought by some critics that the entire policy of establishing training grants and research grants should be carefully and critically reassayed.

The grants are awarded by a Committee on Research of the West Virginia Heart Association. The applicant for a grant makes a written formal application which outlines the purpose of the projected study and also the scientific background of the applicant. The applications are carefully evaluated by members of the Committee and those which seem the most promising are awarded. There are nearly always requests for more projects than the budget allows. Although some of the research is rather technical in nature, some projects have a decided clinical application.

The West Virginia Heart Association is to be highly commended for its support of investigative work. There are many problems concerning the heart and blood vessels which are still unsolved. Only by arduous and painstaking labor can these problems be elucidated. The value of careful and well-planned research needs no defense.

Sugarplums 1973

Christmas bells and Watergate;
Santa Claus and White House tape.

Stockings hung, fuel rationing;
Price control, kids caroling.

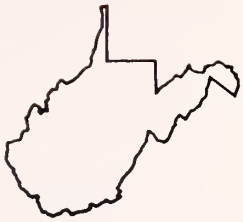
Holy Night, PSRO's;
Medicaid and mistletoes.

Shepherds watch and sentries too;
Bombs away, good will to you.

Mangered Christ, deliver us;
These dreams are sacrilegious.

Stephen D. Ward, M. D.

GENERAL NEWS



Expanded Program And Speakers Spark Interest In Conference

Plans are nearing completion for the Seventh Mid-Winter Clinical Conference to be held in Charleston January 18, 19 and 20 at the Heart-O-Town Motor Inn.

Eleven principal speakers are scheduled for the program which has been expanded to three days this January to include Friday night concurrent sessions on PSRO's and "The Battered Child."

John L. Guerrant, M. D.

E. Gordon Margolin, M. D.

The Conference is approved for credit toward the Physician's Recognition Award of the American Medical Association, and has been submitted to the American Academy of Family Physicians for twelve-and-one-half hours of credit.

The Conference Co-Chairmen, Drs. Joseph T. Skaggs and Ralph H. Nestmann, both of Charleston, are hopeful the Conference will draw a record attendance as a result of the added Friday night sessions, the scheduled speakers and the attraction of the Kanawha Medical Society's annual dinner dance to which conference participants are invited Saturday night, January 19. Attendance at last January's Conference was 144.

Emphasis On Drug Therapy

This January's Conference will offer a wide range of clinical topics with a particular emphasis on drug therapy.

John L. Guerrant, M.D., Professor of Medicine and Chief of Allergy/Pulmonary Disease Section of the Department of Internal Medicine at the University of Virginia School of Medicine at Charlottesville, will speak Saturday morning on "Immunologic and Pharmacologic Basis for the Treatment of Asthma."

A native of Virginia, Doctor Guerrant graduated from Danville Military Institute and Hampden-Sydney College and received his M. D. degree in 1937 from the University of Virginia School of Medicine. He also received an M. S. degree in 1942 from the University of Virginia Graduate School.

Doctor Guerrant interned at Episcopal Hospital in Philadelphia and Kingston Avenue Hospital in Brooklyn, New York. Following a residency at the University of Virginia Hospital in Charlottesville from 1940 to 1942, he served as a Captain in the U. S. Army Medical Corps until 1946. In that year he joined the staff of the University of Virginia School of Medicine.

Doctor Guerrant is a Past President of the Virginia Thoracic Society, the Southeastern Allergy Association and the Virginia Tuberculosis and Respiratory Disease Association.

Speaking Saturday afternoon, January 19, will be E. Gordon Margolin, M.D., Director of the Department of Internal Medicine at Jewish Hospital in Cincinnati, whose topic will be "Some Aspects of Diuretic Management." Doctor Margolin also is Chairman of the Medical Staff Committee on House Staff and Education at Jewish Hospital.

University Of Nebraska Graduate

Doctor Margolin received his undergraduate training at the University of Nebraska and received his M. D. degree in 1947 from the College of Medicine at that institution. He interned at Mt. Sinai Hospital in New York and served residencies at Peter Bent Brigham Hospital in Boston and Mt. Sinai Hospital from 1949 to 1951. Following two years' service with the U. S. Army from 1951 to 1953, Doctor Margolin spent a two-year Fellowship in Renal and Electrolyte Metabolism at Peter Bent Brigham Hospital.

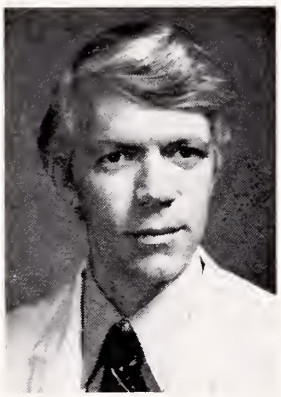
Certified by the American Board of Internal Medicine and a Fellow of the American College of Physicians, Doctor Margolin is Chairman of the Medical Advisory Committee of the Kidney Foundation of Southwestern Ohio, a member of the Advisory Board of the Rehabilitation Counselor Training Program at the University of Cincinnati, and is a Past President of the Cincinnati Association of Parents and Teachers of Deaf and Hard-of-Hearing Children.

Author of Numerous Publications

Clair E. Cox, II, M.D., who will speak Sunday afternoon, January 20, is the author or co-author of 48 scientific publications and has presented numerous papers and lectures throughout the United States and in foreign countries. A urologist, his topic will be "Drug Therapy of Urinary Tract Infections."

Doctor Cox is Professor and Chairman of the Department of Urology at the University of Tennessee Medical Units, College of Medicine, at Memphis. A native of Illinois, he received his M. D. degree in 1958 from the University of Michigan Medical School. He served a rotating internship and a residency in general surgery at the University of Colorado Medical Center in Denver, and a residency in urology at the University of California Medical Center in San Francisco. He is certified by the American Board of Urology and is a Fellow of the American College of Surgeons. He held a faculty appointment in urology at the Bowman Gray School of Medicine of Wake Forest University at Winston-Salem, North Carolina from 1963 to 1972.

Eli H. Newberger, M.D., of Boston, will be the speaker for the public session on "The Battered Child" Friday night, January 18. Doctor Newberger is Director, Family Development Study, at Children's Hospital Medical Center in Boston.



Clair E. Cox, II, M. D.

Eli H. Newberger, M. D.

Serves In Peace Corps

A native of Brooklyn, New York, Doctor Newberger graduated from Yale University and received his M. D. degree in 1966 from Yale University School of Medicine. Following an internship at the Yale-New Haven (Connecticut) Hospital he served in the Peace Corps for two years in West Africa before beginning a residency in pediatrics in 1969 at the Children's Hospital Medical Center in Boston. Doctor Newberger, who also is an Instructor in Pediatrics at Harvard Medical School, received an M. S. Degree in Epidemiology in 1972 from the Harvard School of Public Health in Boston. He also assumed his present position at the Children's Hospital that same year.

Doctor Newberger is the author or co-author of a number of publications, including "The Myth of the Battered Child Syndrome," in *Proceedings, National Symposium on Child Abuse, American Humane Association, Denver, Colorado,* 1972.

Doctor Newberger also will speak at a medically-oriented session on "The Battered Child" Saturday morning, January 19.

Other Speakers And Topics

Other speakers and their topics, as previously announced, will include:

"The Use of Oral Agents in the Treatment of Diabetes"—Charles B. Kahn, M.D., Joslin Clinic, Boston;

"Is It Worthwhile to Treat Hypertension?"—Ray W. Gifford, Jr., M.D., Head of the Department of Hypertension and Nephrology, Cleveland Clinic;

"Cancer Chemotherapy"—Raymond B. Weiss, M.D., Assistant Professor of Medicine, West Virginia University School of Medicine;

"Rational Approach to Antimicrobial Therapy"—Jack L. Le Frock, M.D., Assistant Professor of Medicine, Division of Infectious Diseases, WVU;

"An Over-View of Drug Therapy in Rheumatoid Arthritis"—Irving Kushner, M.D., Professor of Medicine and Chairman, Division of Rheumatology, WVU;

"Current Therapy of Non-Venereal Vaginitis"—Robert D. Patchell, M.D., Director of Obstetrics and Gynecology, Charleston Division, WVU;

"Current Chemotherapy of the Venereal Diseases"—Paul Wiesner, M.D., Chief, Operational Research Section, Venereal Diseases Branch, Center for Disease Control, Atlanta.

Conference Sponsors

The sponsors for the 1974 Conference are:

The West Virginia State Medical Association and its Section on Urology, the West Virginia Chapter, American Academy of Pediatrics; the Department of Pediatrics, Charleston Area Medical Center; the

Kanawha Medical Society Offers Social Event

Physicians, wives and others attending the Mid-Winter Clinical Conference are invited to the annual dinner dance of the Kanawha Medical Society which will be held Saturday, January 19, in the Daniel Boone Hotel ballroom beginning at 7 P.M. The affair will include cocktails, dinner and dancing. Dress will be formal.

The cost will be $10 per person. Advance registration is requested. Registrations and advance payment, if desired, should be sent to the Kanawha Medical Society, 405 Atlas Building, Charleston 25301. Payment also may be made at the door. Checks should be made payable to the Kanawha Medical Society.

All registrations should be in by January 15.

West Virginia Division, American Cancer Society; the West Virginia Diabetes Association, the West Virginia Thoracic Society, the West Virginia Heart Association, the West Virginia Tuberculosis and Respiratory Disease Association, the West Virginia University School of Medicine and Alumni Association; the West Virginia State Health Department, the West Virginia Chapter of the Arthritis Foundation and the Woman's Auxiliary to the Kanawha Medical Society.

ACP Schedules Four January Courses

The American College of Physicians will sponsor four postgraduate courses in January. The course titles, locations and fees for ACP members are:

"Workshops in the Physiology, Diagnosis and Treatment of Electrolyte and Acid-Base Disorders," January 7-11, University of Pennsylvania School of Medicine, $160; "Chemotherapy of Infectious Disease," January 9-12, University of California at San Diego, $120; "Clinical Application of Recent Advances in Medicine," January 21-23, Ochsner Clinic, New Orleans, Louisiana, $100; and "Hematology, 1974," January 21-25, University of Miami (Florida) School of Medicine, $140.

Additional information may be obtained from: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Southern Medical Journal Names New Editor

Dr. Harris D. Riley, Jr., Professor of Pediatrics and Head of the Department of Pediatrics, University of Oklahoma College of Medicine and Pediatrician-in-Chief of Children's Memorial Hospital at the University of Oklahoma Health Sciences Center in Oklahoma City, has been named Editor of the *Southern Medical Journal.*

Doctor Riley has previously served as Pediatric Editor, Assistant and Associate Editor of the *Journal.* Published monthly by the Southern Medical Association, at the headquarters in Birmingham, Alabama, the *Journal* is for SMA members and other physicians and students.

A native of Tupelo, Mississippi, Doctor Riley received the B.A. degree from Vanderbilt University and his M.D. from Vanderbilt University School of Medicine in Nashville, Tennessee. He served his internship and residency training at the Johns Hopkins Hospital and Baltimore City Hospitals in Baltimore; the Babies and Children's Hospital, Western Reserve University in Cleveland; and the Vanderbilt University Hospital in Nashville. Following military service he returned to Vanderbilt University School of Medicine as a Research Fellow of the National Foundation.

Doctor Holbrook Reelected Member Of Publication Committee

Dr. Thomas J. Holbrook of Huntington was reelected a member of the Publication Committee during a meeting of the Council of the West Virginia State Medical Association which was held in Charleston on November 4, 1973.

Thomas J. Holbrook, M. D.

Doctor Holbrook, who has served as a member of the Committee since June, 1972, was elected to a term which expires on December 31, 1980. As a member of the Publication Committee, Doctor Holbrook will serve as an Associate Editor of *The Journal.*

A native of Johnson County, Kentucky, Doctor Holbrook was graduated from the University of Kentucky and received his M.D. degree in 1941 from the Vanderbilt University School of Medicine. He interned at Vanderbilt Hospital and served residencies at that hospital and St. Vincent's Hospital in New York City.

He is a member of Phi Beta Kappa, Alpha Omega Alpha, and was certified by the American Board of Neurosurgery in 1949. He also is a Fellow of the American College of Surgeons.

Doctor Holbrook served as a Captain in the Medical Corps of the U. S. Army, 1942-46.

Child Abuse Theme Of Poster Contest

The Woman's Auxiliary to the Kanawha Medical Society is sponsoring a poster contest for junior and senior high school students in a move to bring attention to the national problem of child abuse.

Seventy-five dollars in cash prizes will be offered and the posters will be used in publicizing a Public Symposium on Child Abuse which is to be held January 18 at 8 P.M. in the Heart-O-Town Motor Inn under Auxiliary sponsorship. Coordinator for the seminar will be Dr. Herbert H. Pomerance, Director of Pediatrics, Charleston Area Medical Center.

The Symposium will be held in conjunction with the Seventh Annual Mid-Winter Conference sponsored by the West Virginia State Medical Association and a number of other affiliated societies and organizations.

Mrs. John J. Schaefer, Jr., Auxiliary President, said "Teen-agers can contribute to the success of the symposium by their participation in the poster contest. They also can contribute to the community by their talent, position as future parents, experience as baby-sitters and their interest in community service."

Fall Meeting of the Council In Charleston on Nov. 4

The Fall Meeting of the Council was held at the Heart-O-Town Motor Inn in Charleston on Sunday, November 4, with the Chairman, Dr. Worthy W. McKinney of Beckley, presiding.

At the outset, Doctor McKinney introduced the following new members of the Council elected at The Greenbrier in August: Drs. Robert R. Weiler of Wheeling, Robert D. Hess of Bridgeport, Louis W. Groves, Jr., of Richwood, Harold D. Kagan of Huntington and J. L. Mangus of Charleston. Another new member, Dr. Robert W. Bess of Piedmont, was unable to attend the meeting.

Uniform Claims Form Developed

Doctor McKinney also introduced Mr. James S. Imboden of Columbus, Ohio, Field Representative for the American Medical Association. Mr. Imboden pointed out that the AMA, in cooperation with the insurance industry and other third-party agencies, had developed a computer-adaptable uniform health insurance claims form which it hopes all physicians, insurance companies and fiscal intermediaries will adopt. He said that one of the primary purposes of adopting the uniform insurance claims form would be to cut down on the medical paper work in physicians' offices.

He suggested that members of the Council urge physicians throughout the State to read carefully the October 29 issue of the *American Medical News* which outlined in detail information concerning development of the new form. He said members of the profession throughout the country would receive further information in the near future.

Proposed Medical School at Marshall University

There was considerable discussion concerning a new medical school at Marshall University in connection with the Veterans Administration. It was pointed out that a meeting of the Committee on Medical Education and Hospitals had been scheduled the day before the Council meeting but had been canceled for various reasons.

Members of the Council agreed that those physicians especially interested in the establishment of a medical school at Marshall University should be given more time to collect and present facts and figures in re the initial and future funding of such a school.

(Subsequently, a meeting of the Committee on Medical Education and Hospitals and a special meeting of the Council were scheduled for Sunday, November 18, 1973).

Resolution Submitted to AMA House of Delegates

It was reported that a resolution had been submitted to the House of Delegates of the American Medical Association which would amend the By-Laws so that the Immediate Past President of the AMA would automatically assume the office of Chairman of the AMA Board of Trustees upon conclusion of annual conventions usually held during the month of June.

Under the present By-Laws, the Board of Trustees elects the Chairman from within its own membership at the first organizational meeting at the conclusion of the annual convention.

The Council unanimously approved the resolution and requested that efforts be made to gain support of AMA delegates from other states. The resolution was introduced during the Clinical Convention early this month in Anaheim, California, and was referred immediately to a reference committee for study and a report back to the House of Delegates.

Doctor McKinney pointed out that resolutions submitted by other states were being reported weekly in the *American Medical News*. He requested that members of the Council urge their colleagues to make known to the West Virginia delegates and alternates their views on resolutions which should be supported or opposed by the West Virginia delegation at the Anaheim Convention.

Publication Committee Member Reelected

Dr. Thomas J. Holbrook of Huntington was reelected a member of the Publication Committee for the term ending on December 31, 1980. As a member of the Publication Committee, Doctor Holbrook will serve as an Associate Editor of *The West Virginia Medical Journal* and will assist in reviewing the scientific and editorial material submitted for publication in *The Journal*.

Election of Honorary Members

Drs. B. S. Brake and James G. Ralston, both of Clarksburg, were elected to honorary membership in the State Medical Association.

Report on West Virginia Medical Institute, Inc.

There was considerable discussion concerning recent developments in the West Virginia Medical Institute, Inc., which was formally organized on September 30. It was pointed out that the organizational meeting was held in Charleston on that date and Dr. Harry S. Weeks, Jr., of Wheeling, had been elected the initial President of the Institute.

Doctor Weeks reported that membership in the Institute is open to all doctors of medicine and osteopathy licensed to practice in West Virginia and that a letter of invitation to join the Institute had been mailed to these physicians early in October. He said the response had been most encouraging and indicated that a substantial number of physicians had applied for membership in the Institute.

Mr. Charles R. Lewis, Special Projects Director for the Association, reported he had visited a number of component societies to outline activities of the Institute and he expressed appreciation for the invitations to be present at meetings throughout the State.

Proposed Changes In Medical Practice Act

Dr. N. H. Dyer, Secretary of the Medical Licensing Board, reported that Board Members had been studying possible changes in the Medical Practice Act of West Virginia and should be in a position to prepare a bill to amend the present law during the 1974 session of the West Virginia Legislature.

Doctor Dyer reviewed a number of the proposed changes, and members of the Council directed that this information be referred to the Ad Hoc Committee of the Association named earlier this fall to assist the MLB in determining whether changes are needed to be made in the law governing licensure of physicians in the State.

Doctor Dyer also was requested by the Council to explore the possibility of preparing a bill to eliminate the requirement that physicians be registered by the State under the Controlled Substances Act since the requirement simply duplicates the Federal law.

European Adventure Approved

The Council endorsed a travel medical seminar for all members and families of the West Virginia State Medical Association which will include visits to three cities in Switzerland, Austria and Germany. The coordinator of the European Adventure—INTRAV—has indicated that the departure date for Europe will be July 24, 1974. It was pointed out that the same travel organization had coordinated three previous successful trips for members of the Association to the Orient, Mediterranean and Scandinavia.

Representatives of INTRAV indicated that details concerning the European Adventure would be mailed to the entire membership early in 1974.

Need of Physician in Clay County

It was reported that the Health Planning Council, representing Boone, Clay, Kanawha and Putnam Counties, plans to submit an application to the National Health Service Corps to supply a physician in Clay County until such time as a permanent physician can be obtained. It was pointed out that currently there is no physician to serve the more than 9,000 residents of the county.

Council voted to endorse the project with the provision that the Health Planning Council also obtain endorsement of the Kanawha Medical Society.

Report of Medical Economics Committee

Dr. W. Alva Deardorff, Vice Chairman of the Medical Economics Committee, reported that members of the Sub-Committee on Workmen's Compensation had met on October 31 with officials of the Workmen's Compensation Fund. He said that the meeting results in promoting a much better rapport between members of the Committee and Acting Commissioner William D. Mitchell and members of his staff.

Doctor Deardorff also reported that members of the Committee met in August with Dr. Leslie F. McCoy, Medical Director of the Division of Vocational Rehabilitation. He said at that time Doctor McCoy had requested that a committee be named from the membership of the Association to assist him in finding solutions to some of the problems existing in the Rehabilitation program. Doctor Deardorff reported that Dr. A. Thomas McCoy, President of the Association, had appointed an Ad Hoc Committee to lend assistance to the Medical Director of the Rehabilitation Division.

The meeting was attended by Dr. Worthy W. McKinney of Beckley, Chairman; Dr. A. Thomas McCoy of Charleston, President; Dr. William E. Gilmore of Parkersburg, President Elect; Dr. Jack Leckie of Huntington, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. Harry S. Weeks, Jr., of Wheeling, Councilor at Large; Dr. George R. Callender, Jr., of Charleston, Junior Councilor; Drs. Robert R. Weiler of Wheeling; Robert G. Janes of Fairmont; Thomas P. Long of Man; Robert R. Pittman of Martinsburg; L. H. Nefflen of Elkins; Robert D. Hess of Bridgeport; Louis W. Groves, Jr., of Richwood; F. Lloyd Blair of Parkersburg; Harold N. Kagan of Huntington; W. Alva Deardorff and J. L. Mangus of Charleston; Richard G. Starr of Beckley; and John J. Mahood of Bluefield; Mr. William H. Lively of Charleston, Executive Secretary; Mr. Custer B. Holliday of Charleston, Executive Assistant; and Mr. Charles R. Lewis of Charleston, Special Projects Director.

Also attending the meeting were Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer, Director of the State Health Department; Dr. Mildred Mitchell-Bateman, Director of the State Mental Health Department; and Mr. James S. Imboden of Columbus, Ohio, AMA Field Representative.

Coffee Drinking Ruled Out As Cause Of Heart Attacks

Coffee drinking does *not* cause heart attacks, says a California research report published in a recent issue of the *Journal of the American Medical Association.*

A report earlier this year of possible association between coffee drinking and acute myocardial infarction (heart attack) received widespread publicity in the press. The report first appeared in *Lancet*, a British medical publication.

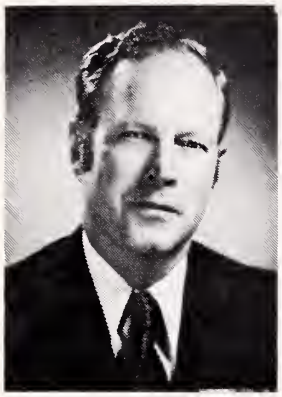
In a study conducted among patients at the Kaiser-Permanente Medical Center, Oakland, California, a research team reports:

"No independent association between coffee drinking and a subsequent first myocardial infarction in 464 patients was found."

The patients were recorded for cigaret smoking and other factors that increase risk of heart attacks, such as high blood pressure and high cholesterol level in the blood.

Dr. William E. Gilmore New Governor For West Virginia Chapter, ACS

Dr. William E. Gilmore of Parkersburg has been elected to serve as Governor of the West Virginia Chapter of the American College of Surgeons. Announcement of his election was made during the Annual ACS Clinical Congress held in Chicago in October. He succeeds Dr. Charles D. Hershey of Wheeling who had served two terms as Governor for West Virginia. Governors serve a three-year term and may not serve more than two terms in succession.



William E. Gilmore, M. D.

Doctor Gilmore, who is currently serving as President Elect of the West Virginia State Medical Association, will serve as the communication link between members of the West Virginia Chapter and the Board of Governors of the ACS.

A native of Wheeling, Doctor Gilmore graduated from West Virginia University and received his M.D. degree in 1943 from the University of Wisconsin School of Medicine. He interned at Philadelphia General Hospital and served a residency in general surgery at the State of Wisconsin General Hospital. He is a Diplomate of the American Board of Surgery and a member of a number of other surgical organizations.

Doctor Gilmore has been active in the Parkersburg Academy of Medicine and the State Medical Association for a number of years and was a member of the Council of the Association from 1966 until 1970.

ACS Spring Meeting Scheduled In Houston, Mar. 25-28

Continuing a major change in its long-range educational program, the American College of Surgeons will sponsor its second annual four-day Spring Meeting in Houston on Monday, March 25 through Thursday, March 28, 1974, at the Albert Thomas Convention Center and the Hyatt Regency Hotel.

The meeting will provide eight postgraduate courses, some of which will involve plenary sessions, followed by splitting into smaller groups to facilitate participation and discussion. The precise format will be determined by the presiding chairman. A surgeon may choose one of four courses during the first two days of the meeting, and select another from four other offerings in the second two days.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1973

Dec. 1-4—Am. Soc. Hematology, Chicago.
Dec. 1-6—Am. Acad. of Derm. Chicago.
Dec. 1-5—AMA Clinical, Anaheim, Calif.
Dec. 3-5—So. Surg. Assn., Hot Springs, Va.

1974

Jan. 6-8—Soc. of Gyn. Oncol., Key Biscayne, Fla.
Jan. 18-20—Mid-Winter Clinical Conf., Charleston.
Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.
Jan. 19-24—Am. Acad. Ortho. Surgeons, Dallas.
Jan. 20-24—James C. Kimbrough Urol. Sem., Silver Spring, Md.
Jan. 21-23—Hemophilia (N. Y. Acad. of Sciences & Natl. Hemo. Found.) N. Y.
Jan. 25-27—So. Rad. Conf., Point Clear, Ala.
Jan. 25-27—AMA Natl. Leadership Conf., Chicago.
Jan. 28-30—Soc. of Thoracic Surgeons, L. A.

Feb. 1-3—AMA Council on Med. Educat. Congress, Chicago.

Feb. 10-16—Am. Soc. of Contemp. Ophthal., Miami Beach.
Feb. 10-16—Am. Soc. of Contemp. Med. & Surg., Miami Beach.
Feb. 11-14—Am. Coll. Card., N. Y.
Feb. 13-16—National Assn. Med. Examiners, Dallas.
Feb. 14-16—Soc. Univ. Surgeons, St. Louis.
Feb. 24-28—Med. Soc. State of N. Y., N. Y. City.

Mar. 1-3—Student Am. Med. Assn., Dallas.
Mar. 7-9—Central Surg. Assn., Cincy.
Mar. 15-17—AMA-AMPAC Pub. Affairs Workshop Washington, D. C.
Mar. 24-25—Am. Soc. Clinical Pharmacology and Therapeutics, Maui, Hawaii (San Francisco, Mar. 28-29).
Mar. 25-27—Am. Coll. Surgeons, Houston.
Mar. 28-29—Am. Bd. Med. Specialties, Chicago.
Mar. 29-April 3—Am. Soc. Abdom. Surgeons, Las Vegas.
Mar. 31—April 5—Am. Coll. Physicians, N. Y.

April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.
April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.
April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.
April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.

May 12-15—Am. Thoracic Soc., Cincy.
May 12-15—S. Carolina Med. Assn., Myrtle Beach.
May 12-15—Ohio State Med. Assn., Cleveland.
May 12-16—Am. Assn. Plastic Surgeons, Seattle.
May 16-18—Childhood Cancer, Dallas.
May 17-18—Am. Assn. Clin. Urologists, St. Louis.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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WVU Medical Center
–News–

NEUTRON therapy, a promising form of treatment for some cancerous tumors, recently became available to the State's residents through the West Virginia University Medical Center.

The treatments, administered at the Naval Research Laboratory cyclotron in Washington, D. C., are coordinated for the WVU Medical Center by Dr. John C. Evans, Professor and Chief of the Division of Radiation Therapy, Department of Radiology.

The project will help determine whether or not neutron radiation is significantly better than other types of radiation such as x-rays and gamma rays in controlling or curing some types of localized tumors.

Cancer patients from seven eastern states and the District of Columbia will be selected to take part in the program—one of only two in the United States.

Neutron therapy has been carried on for the past year at the M. D. Anderson Tumor Institute in Houston, utilizing the cyclotron at Texas A. and M. located at College Station. Within a short time, the University of Washington in Seattle expects to use a cyclotron for cancer treatment.

The therapy utilizes a type of radiation called fast neutron beams, created by a cyclotron, to irradiate and destroy cancerous tissues. Tried in 1938 by the University of California in Berkeley, it was abandoned as a form of treatment because of the significant incidence of damage to normal tissues. Since then, sophisticated principles have been found which should curtail damage to normal tissue. Controlled clinical trials were begun two years ago at Hammersmith Hospital in London after more than a decade of intensive radiobiological research.

Mrs. Marguerite Abel, Assistant Librarian at the West Virginia University Medical Center, requests the computer at the National Library of Medicine to provide a bibliography wanted by Craig Abolin of Morgantown, a graduate student in pharmacy. The terminal console used by Mrs. Abel is directly connected by telephone to this computer at Bethesda, Maryland, but may be used to tap other data banks throughout the United States by means of access nodes.

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

Patients will be selected by 18 physicians at radiation therapy centers in medical centers from Philadelphia to Atlanta. Their participation in the program is voluntary.

Initially, patients will receive two treatments a week for a period of seven weeks. They will generally commute from their homes to Washington, or will stay in a nearby hotel during the treatment period. Some hospital beds will be made available for persons requiring special care.

There will be no charge for treatment. The grant also provides funds for incidental expenses for those unable to pay.

Computer Finds Information

Robert L. Murphy, Librarian at West Virginia University's Medical Center Library, has numerous long-distance telephone conversations with a computer.

So do the Assistant Librarian, Marguerite Abel, and Jane Fulcher, Head of the library's Technical Division.

The three are analysts trained to operate the library's terminal console which is connected by a dedicated telephone line to the MEDLINE computer at the National Library of Medicine in Bethesda, Maryland.

Their conversations aren't vocal. They query the computer by way of the console's typewriter-like keyboard, and the computer answers with a print-out using the same instrument.

Actually the computer doesn't provide medical opinion or research results, nor does it diagnose rare diseases. It just tells what has been written about these and other medical subjects and where such information can be found.

Murphy and his two assistants have been trained in the vocabulary needed to tap the computer's vast memory bank, which is an index of more than 400,000 citations from about 1,200 of the world's leading medical journals.

When queried about a subject, the computer can provide the number of postings it has, can narrow it down by its specific aspects, and can, upon request, print out a bibliography. All of this takes only minutes.

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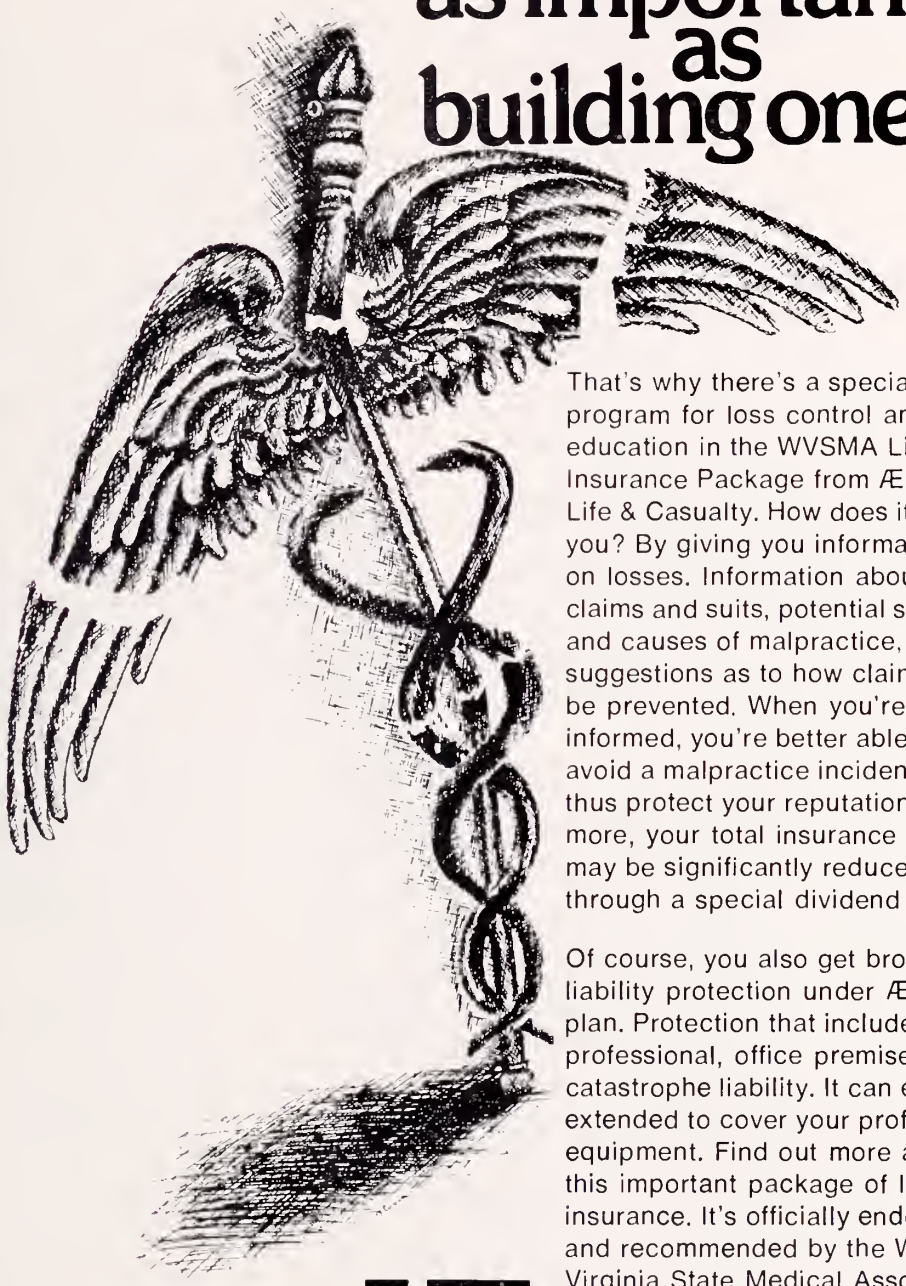

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE debate concerning the right of large states to establish statewide Professional Standards Review Organizations (PSRO's) has apparently come to an abrupt halt with the government saying "no" in a loud and clear voice.

The Department of Health, Education and Welfare announcement came only 10 days after it had released a statement that said under certain circumstances it would consider naming a statewide PSRO in big states where there is support for it among the interested medical and health groups.

Though an about face was denied by Henry Simmons, M. D., Deputy HEW Assistant Secretary for Health and acting head of PSRO, there was an apparent conflict between the statement given earlier to the PSRO Advisory Council and the final decision.

The designated PSRO areas which were to be announced by late November or early December will include no area having many more than 3,000 physicians within it, Doctor Simmons told a news conference in his office. He conceded there is no such limitation in the PSRO law, but the 2,500-physician level suggested in the report by the Senate Finance Committee was "reasonable" but not "rigid."

The area selections will be in the form of proposals printed in the Federal Register giving interested parties 30 days in which to comment. The possibility remains that some changes could be made before the designations become final, but Doctor Simmons did not talk as if there was much chance of that happening.

In the earlier statement given the Advisory Council, Doctor Simmons said: "There are a few states with a larger number of physicians that have requested that they also be designated as single state PSRO's and have obtained backing of their medical, osteopathic and hospital associations and, in some instances, government. In such instances, we will individually consider designation of a statewide PSRO if the statewide PSRO has support of physicians throughout the state and agrees to further subdivide itself . . . and if control of the review process remains at the local levels. . . .

"Thus, in states with a large number of physicians which nevertheless opt for a statewide PSRO, it is clear that the review of care would be controlled and performed locally. . . ."

Members of the Council interpreted this as indicating that HEW in some cases might okay a statewide PSRO in large states.

Doctor Simmons also told the news conference that guidelines will be issued in February on how organizations can apply to become PSRO's within the designated areas. By next June, he said, the hope is to have 50 PSRO's chosen. Within four to six weeks a PSRO bulletin will be sent to all physicians in the nation outlining the status of the program and informing them of PSRO developments.

He predicted from 20 to 30 small states will be single-state PSRO areas.

PSRO, said Doctor Simmons, is "probably the most sensitive program that has been mandated" for the medical profession "and one of the most important ever passed in terms of impact upon the profession and benefit to the public."

He praised the AMA for "very constructive steps" in developing diagnostic standards for PSRO and "very constructive work in general" with HEW in gearing up for the program. He conceded a difference of opinion with the AMA on the extent to which PSRO's would function at the state level.

Action of Senate Finance Committee

Prior to the HEW decision against statewide PSRO's in large states, the Senate Finance Committee had tentatively approved a provision that would ban HEW from using a limitation on the number of physicians that may belong to a PSRO.

If enacted, the provision could make it easier for statewide PSRO's to win HEW approval.

At present, the Department is employing a general top limit of 2,500 physicians per review organization, a maximum guide that obviously would foreclose larger states from having a single organization to review institutional care for Medicare and Medicaid patients.

The amendment was sponsored by Sen. Lloyd Bentsen (D.-Texas) and agreed to by Sen. Wallace Bennett (R.-Utah), originator of the PSRO concept and a staunch proponent of smaller PSRO units.

The language of the proposed Bentsen amendment reads: "In carrying out the provisions of this section, the Secretary may designate, as an appropriate area with respect to which a Professional Standards Review Organization may be designated, an area encompassing a whole State; and the Secretary shall not refuse to designate any qualified organization as the Professional Standards Review Organization with respect to such area solely because of the number of physicians participating in such Organization."

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Obituaries

THOMAS B. BAER, M. D.

Dr. Thomas B. Baer, Bluefield urologist, died on October 17 at his home following a long illness. He was 57. Doctor Baer, a native of Logan, had been a member of the staff at Bluefield Sanitarium since 1951.

He was educated at West Virginia University and Marshall University, receiving his M. D. degree in 1942 from the Medical College of Virginia in Richmond. He interned at Chesapeake and Ohio Hospital in Huntington.

Doctor Baer served in the U. S. Army Medical Corps during World War II and was retired with the rank of Major. Following the war he was associated in practice with Dr. Charles A. (Carl) Hoffman of Huntington and later was in private practice there. He was a member of the American Board of Urology.

He was a member and Past President of the Mercer County Medical Society, and a member of the West Virginia State Medical Association, the American Medical Association, the Mid-Atlantic Section of the Urological Association and the Southeastern Surgical Congress. While in Huntington he had been Secretary of the Cabell County Medical Society.

Survivors include the widow, three daughters, Mrs. Michael Hodges of Nashville, Tennessee; Miss Catherine Baer of Knoxville, Tennessee, and Mrs. Douglas White of Fort Wayne, Indiana; two granddaughters; his mother, Mrs. Ira P. Baer; and two brothers, Peter and Phillip Baer, all of Huntington.

* * * * *

SAMUEL J. FERGUSON, M.D.

Dr. Samuel J. Ferguson of Wayne, a family physician who had practiced in Wayne County for 49 years, died on October 8 in a Huntington hospital. He was 78.

He was a graduate of West Virginia University and received his M.D. degree in 1924 from the Medical College of Virginia in Richmond.

Survivors include the widow, two daughters, Mrs. Marian Hanna of Charleston and Mrs. Francis Cogar of St. Albans; four brothers, Judge C. W. Ferguson, II, and Milton J. Ferguson, both of Wayne; and L. Wallace Ferguson and Joseph M. Ferguson, both of Albuquerque, New Mexico; and two sisters, Mrs. Lillian F. Steffey of Huntington and Mrs. Lucille F. Alexander of Charleston.

* * * *

A. W. MILHOAN, M.D.

Dr. A. W. Milhoan of Nitro died on October 19 at his home. He was 78.

A native of Murraysville (Jackson County), Doctor Milhoan was a graduate of West Virginia University and received his M.D. degree in 1927 from the University of Maryland School of Medicine. He served a residency at Cook County Hospital in Chicago.

From 1928 to 1947, Doctor Milhoan was a family physician in Nitro, and from 1947 until 1970 he did limited clinical diagnosis work.

A World War I U. S. Navy veteran, he was a screening examiner for the Induction Center in Huntington during World War II and was plant physician for American Viscose Corporation and Monsanto Chemical Corporation from 1928 to 1945.

Doctor Milhoan was an insurance examiner and a Diplomate of the National Board of Medical Examiners. He was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are a son, John W. Milhoan of Gallipolis, Ohio, and a brother, Okey Milhoan of Winigan, Missouri.

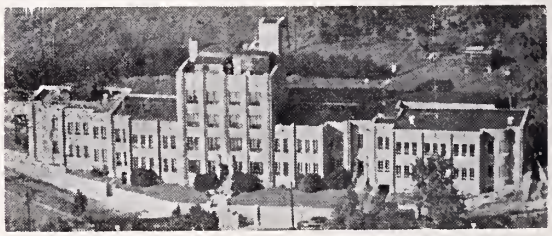
* * * *

DIEGO NUNNARI, M.D.

Dr. Diego Nunnari, formerly of Oak Hill, died September 28 in Rome, Italy following a long illness. A former staff member of Oak Hill Hospital, he was 58. A native of Maybeury (McDowell County), Doctor Nunnari received his medical education in Italy, earning his M.D. degree in 1943 from the University of Bologna.

He remained in Italy for an internship and postgraduate work in obstetrics and gynecology, returning to this country to serve a residency at Oak Hill Hospital from 1951 to 1955. He had been with the

(Continued on Page xvi)



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hospital for 22 years when he returned to Italy last January.

Doctor Nunnari was a member of the Fayette County Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Doctor Nunnari is survived by a brother, Pietro of Reggio Calabria, Italy, and three sisters, Mrs. Concetta Strangio of Rome, Italy, and Mrs. Antoinetta Mussolini and Lena Nunnari, both of Reggio Calabria.

* * * *

THURMAN E. VASS, M.D.

Dr. Thurman E. Vass of Bluefield, a retired surgeon and one of the founders of St. Luke's Hospital there, died on October 5 in Bluefield. He was 84.

Doctor Vass was a graduate of Concord Normal School, West Virginia University, and received his M.D. degree in 1914 from the College of Physicians and Surgeons in Baltimore.

Surviving are the widow, and one sister, Mrs. John R. Davis of Weston.

Health Insurance Covers 170 Million Under 65

Some 170 million persons under age 65 in the United States have private health insurance, the Health Insurance Institute reported recently.

This was one of the major findings in the Health Insurance Council's 27th annual survey on the extent of private health insurance coverage in the United States. It showed that as 1973 began, about 9 out of 10 of the U.S. civilian resident population in the under 65 age group was insured—two million more than the preceding year.

The number of persons under age 65 with surgical expense insurance was almost 157 million at the start of this year, two million more than were insured a year earlier.

The HIC survey used data from insurance companies, government agencies and Blue Cross, Blue Shield and medical society plans. For the under 65 population, it found:

- An increase of more than one million persons covered for non-surgical medical expense, for a total of 134½ million. (This insurance covers non-surgical physicians' visits and x-ray and laboratory expenses).

- More than 77½ million persons covered by major medical expense policies—an increase of more than one million from a year earlier. (This insurance handles catastrophic-type medical bills).

The survey also found there were 8.9 million persons covered by dental insurance policies written by insurance companies, an increase of more than a million people.

County Societies

CABELL

The Cabell County Medical Society met on September 13 at the Holiday Inn in Huntington.

Dr. Winfield C. John of Huntington presented the latest information concerning statewide Professional Standards Review Organizations (PSRO's) and outlined the various approaches that the local Society and hospitals can take to comply with federal regulations. He strongly urged that any physician's time required for review be compensated appropriately.

The next regular meeting of the Society was held on October 11 again at the Holiday Inn in Huntington. Dr. Charles Shuman, the guest speaker, gave an interesting talk on diabetes in adults. Dr. Harry K. Tweel of Huntington reported on the current status of the proposed medical school at Marshall University.

Dr. Thomas W. Nale of Huntington advised the Society of the increased incidence of venereal disease and the increasing laxity in proper polio vaccination.—Charles H. McKown, Jr., Secretary.

* * * * *

MERCER

The Mercer County Medical Society met on October 15 in Bluefield at the University Club.

Dr. Frank J. Holroyd of Princeton, Chairman of the Medical Licensing Board of West Virginia, spoke on actions of the Board and stated that any physician having a temporary license, as a graduate of a foreign country, must take the FLEX examination within one year. If the examination is not passed, the physician must take it again within 12 months. If he does not pass the second time, no further temporary license will be issued.

Doctor Holroyd also advised individual physicians to join the West Virginia Medical Institute, Inc.—John J. Mahood, M. D., Secretary.

* * * * *

McDOWELL

The McDowell County Medical Society met on Wednesday, October 10 at Doctors Memorial Hospital in Welch.

A pregram on "Strokes—Clinical and Diagnostic Aspects," was presented by Dr. Guy E. Irvin of Welch. A film was shown which presented pathological, physiological and clinical findings on strokes occurring at different areas in the brain and also illustrated some of the possible treatments.

A letter from the West Virginia Medical Institute, Inc. of Charleston was read. It was the consensus of the membership present that members of this Society should accept the invitation in the letter to join the Institute.

The problem of home nursing services was discussed, and Dr. John H. Murry, County Health

Department Director, was consulted on this. No definitive action was taken.

The Diabetes Detection Drive, which was to be conducted in the county in November, was discussed.

The Society approved a donation of $30 for *Pylon*, the West Virginia University School of Medicine's Yearbook.—Arthur A. Carr, M. D., Secretary.

* * * * *

MONONGALIA

Dr. A. Thomas McCoy of Charleston, President of the West Virginia State Medical Association, was the guest speaker at the Meeting of the Monongalia County Medical Society on October 2 in Morgantown at the Lakeview Inn and Country Club.

Doctor McCoy, whose topic was "Unity," stressed the need for doctors to work together to implement the PSRO program. He also mentioned that doctors had been consumer advocates long before Ralph Nader thought of the term in that they had devised many methods of protecting the patient down through the years. His speech was well received by the membership.

A letter from Dr. George T. Ralph was read to the group. He is a third-year Family Practice resident at the Akron (Ohio) General Medical Center. He is interested in practicing in West Virginia in a medium-sized community and would prefer a partnership or small group to join.

Dr. Isaiah A. Wiles of Morgantown reported for the Public Health Committee and discussed both the cholera and local meningitis scares.

Dr. John E. Jones, Acting Dean of the West Virginia University School of Medicine, and Dr. Peter Leo Hein, Associate Professor in the Department of Psychiatry, were accepted as new members.—H. Summers Harrison, M. D., Secretary.

Laryngology and Bronchoesophagology PG Course in Chicago

The Department of Otolaryngology, Abraham Lincoln School of Medicine of the University of Illinois and the Eye and Ear Infirmary of the University of Illinois Hospital, will conduct a continuing education course in Laryngology and Bronchoesophagology, March 18 to 23, 1974.

The course is limited to 20 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals.

Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested physicians should write directly to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Sreet, Chicago, Illinois 60612.

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HARRISON

"The Future of Midwifery in West Virginia" was the program for the dinner meeting of the Woman's Auxiliary to the Harrison County Medical Society on November 1 in Clarksburg at the Stonewall Jackson Hotel.

This subject was presented by Mrs. Natalie Stafford, R. N., and Miss Nancy Lee Schnell, R. N., Assistant Professors in Maternity and Nursing at the University Hospital School of Nursing in Morgantown.

Some of the highlights of their presentation were:

"The nurse midwife can manage delivery but also helps the patient manage this for herself during her pregnancy and after delivery."

"The aims of maternity care today are: What the consumer really deserves, education of students, working with the physician, and assisting the mother and family to take on a new role."

A question-and-answer session followed.

A short business session was held at the conclusion of the program.—Mrs. Richard F. Fiester, Publicity Chairman.

Bone And Joint Radiology Symposium At UK

The Departments of Diagnostic Radiology and Orthopedic Surgery at the University of Kentucky Medical Center, Lexington, Kentucky, will conduct a Symposium on Bone and Joint Radiology May 1-3, 1974, immediately preceding the 100th Renewal of the Kentucky Derby.

In the morning session a distinguished guest faculty will analyze radiographs of selected unknown cases that demonstrate differential diagnostic features of various types of bone and joint pathology. Each registrant will be sent copies of the radiographs of each case prior to the meeting. Afternoon sessions will be devoted to informal discussions between small groups of registrants and a member of the guest faculty.

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Society Gearing To Grapple With Alcoholism Problem

A growing public and professional awareness of the perils and prevalence of alcoholism and indications society finally is gearing to grapple with the problem meaningfully were reported at the Conference on Medical Complications of Alcohol Abuse presented by the American Medical Association in Washington, D. C.

Cautious optimism, a feeling that perhaps a corner had been turned, marked the attitudes and statements of many of the 300 speakers and participants at the Conference co-sponsored by the National Council on Alcoholism and the National Institute on Alcohol Abuse and Alcoholism (NIAA).

The meeting came at a time Congress is voting millions of additional dollars for federal alcoholism programs and the Administration is upgrading the effort within the HEW Department.

Morris Chafetz, M.D., Director of the NIAA, said, "it is time we stopped blaming sick people for their own illness and our inability to provide appropriate treatment—especially since the care-givers are in fact the very ones who have conspired to stack the cards against them."

The AMA first recognized alcoholism as an illness back in 1956, Doctor Chafetz said, "yet even today more than half of our nation's hospitals will not admit patients with a primary diagnosis of alcoholism."

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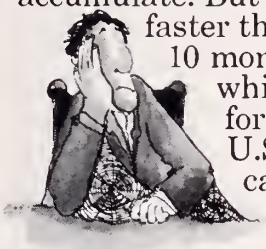

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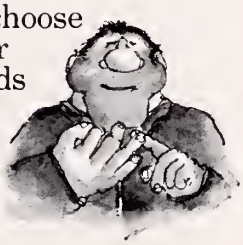

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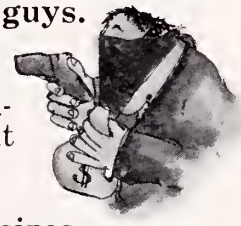

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WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

NOTICE—Grafton City Hospital is pleased to announce its affiliation with Alderson-Broaddus College as a primary institution for the training of physicians assistants and nurses. Needed to augment the medical staff are a general practitioner, internist and an obstetrician-gynecologist. New hospital will be completed within three months and the training program will start in September 1973. Salary and subsidies can be arranged. Contact Wallace B. Murphy, M.D., Chief of Staff, Grafton City Hospital, Grafton, West Virginia 26354.

FAMILY PHYSICIANS—To practice at Jackson General Hospital and in the Ripley-Ravenswood area of West Virginia. Excellent opportunities in a prosperous area with tremendous growth potential. Salary guarantee for first year. Contact Administrator, Jackson General Hospital, Ripley, West Virginia 25271. Telephone: (304) 372-2731.

WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mrs. J. Carl Rinehart, Pennsboro, W. Va.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

WANTED—General practitioner, internist, pediatrician and emergency room physician to associate with other specialties in small town in Southern West Virginia. Accredited 82-bed hospital and new clinic building. Excellent working conditions. Short-term appointments available. Contact Jorge J. San Pedro, M.D., Man, W. Va. (304) 583-6541.

EMERGENCY ROOM PHYSICIAN—Fully accredited 260-bed general hospital in the center of the Mid-Ohio Valley at Parkersburg, W. Va. Contact A. P. Brooks, Jr., M. D., Parkersburg, W. Va. Telephone 485-6456.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

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WANTED—Two general practitioners in Marlinton, Pocahontas County. A 42-bed general hospital is available. Successful practice practically assured and assistance will be offered in locating office space. Call Mr. S. E. Drumm, Administrator, Pocahontas Memorial Hospital in Marlinton, collect, for particulars (304) 799-4193.

EMERGENCY ROOM PHYSICIAN — Accredited 280-bed progressive general hospital in beautiful Huntington, West Virginia; excellent income and working conditions; send resume to Assistant Administrator, Cabell Huntington Hospital, 1340 Sixteenth Street, Huntington, West Virginia 25701.

SURGICAL RESIDENCY AVAILABLE: Large metropolitan hospital, fully accredited for residency training. Contact Bert Bradford, Jr., M. D., Director of Surgery, Charleston Area Medical Center, 3200 MacCorkle Avenue, S. E., Charleston, W. Va. 25304.

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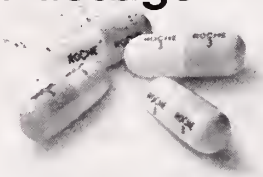

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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